USD 439 CONSENT FOR COVID-19 TEST

I authorize USD 439 to administer Abbott BinaxNOW COVID-19 AG testing (rapid test) in conjunction with the Harvey County Health Department (HCHD) to potentially detect COVID-19 for (name): _____ (DOB)_____. I understand that this testing program is voluntary.

I authorize my test results to be disclosed to USD 439, the Harvey County Health Department, and the Kansas Department of Health and environment and understand that such disclosure will also be made consistent with applicable law.

I acknowledge that a positive test result is an indication that I must abide by USD 439's exclusion policies and all applicable federal, state and/or local guidance on isolation and quarantine to avoid infecting others.

I understand that by signing this document and agreeing to undergo covid-19 testing that I am not creating a patient relationship with USD 439. I understand that USD 439 is not acting as my medical provider. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care, and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur. I, the undersigned, do hereby consent to being tested for the presence of SARS-CoV-2. I consent to testing freely and voluntarily.

Printed Name:_____

Signature:_____

Relationship: _____ Date: _____ D.O.B. _____

(Parent DOB is needed for the State lab. They will not accept a requisition on a minor without the parents DOB.)