Testing Date: _____________

Registration and Consent Form for Rapid COVID-19 Antigen Testing

Personal Information

First Name: ______________________ Middle: ________________ Last Name: ______________________

DOB: (mm/dd/yyyy) ____ /____ / ______ Email Address: ______________________________

Home Address: ____

City/State/Zip: ____

Phone Number: ( ) - ______ - _______ Biological Sex (circle): Male Female

MSU student: yes no Onset Date of Symptoms:______________ **or** Date of Exposure:____________

Race: Please check the box next to the one that best describes your race.

- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Asian
- ☐ White/Caucasian
- ☐ Hawaiian/ Pacific Islander
- ☐ One or more
- ☐ Other
- ☐ Unknown or Decline to specify

Hispanic or Latino: Please check the box next to one of the following that best describes your ethnicity.

- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic
- ☐ Unknown or Decline to specify

Please carefully read the following notice and sign the authorization to test for COVID-19.

1. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test.
2. I understand that I am not creating a patient relationship with the ordering physician by participating in this testing. I understand the entity performing the test is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results and my medical care. I agree I will seek medical advice, care, and treatment from my medical provider or other health care entity if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens.
3. I understand it is my responsibility to inform my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
4. I understand and acknowledge that a positive antigen test result is an indication that I need to self-isolate to avoid infecting others.
5. I understand and acknowledge that if I am symptomatic and receive a negative antigen result it is recommended to consider confirmatory testing with a PCR test or another antigen test (24-36hrs between antigen tests).
6. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 diagnostic test at the testing site.
7. I understand that I may withdraw my consent to participate in testing at any time.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

- ☐ I agree to undergo the COVID-19 antigen testing/ authorize my child to undergo testing.

____ __________________________

Patient/Parent/Legal Guardian Signature Date

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Relationship to Patient