Testing Date: _____ Gallatin City-County Health Department

# 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**: ( ) - _____ - _____ **Sex** (circle): Male Female **MSU student**? yes no

**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

**Is this your first COVID19 test of any kind?**

- ☐ Yes
- ☐ No If no, what type of test was the most recent prior test? (Antigen, Molecular/PCR, Antibody or Unknown)
  - What was the result? _____

**Are you employed in healthcare with direct patient contact?**

- ☐ Yes
- ☐ No

**Have you had any symptoms in the last few days?**

- ☐ If yes, what was the date of the symptoms onset? _____
- ☐ If yes, what symptoms have you had:
  - ☐ Fever over 100.4F
  - ☐ Feeling feverish
  - ☐ Chills
  - ☐ Rigors
  - ☐ Muscle aches
  - ☐ Runny nose
  - ☐ Sore Throat
  - ☐ Change in taste or smell
  - ☐ Headache
  - ☐ Fatigue
  - ☐ Cough
  - ☐ Wheezing
  - ☐ Shortness of breath
  - ☐ Difficulty breathing
  - ☐ Chest pain
  - ☐ Nausea or vomiting
  - ☐ Abdominal pain
  - ☐ Diarrhea (3 or more loose stools/24hr period)
  - ☐ Other (please specify):_____
- ☐ If no, date of exposure:_____

**Do you live in an assisted living facility or congregate care setting?**

- ☐ Yes If Yes, what type of residence is it/name of facility?_____
- ☐ No

**Are you pregnant?**

- ☐ Yes
- ☐ No

**Have you received a COVID-19 Vaccine? If so, please select type and list dates:**

- ☐ **Janssen/Johnson & Johnson Date: _____**
- ☐ **Moderna 1st dose:_____ 2nd dose:_____ Booster or 3rd dose:_____**
- ☐ **Pfizer 1st dose:_____ 2nd dose:_____ Booster or 3rd dose:_____**

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**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 (36hrs between antigen tests).
6. I have been informed of the test purpose, procedures, and potential risks and benefits. I understand this is a self-swabbing testing site and if the patient is 14 or younger a parent or guardian will collect the sample. 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

_____

Relationship to Patient

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*For testing staff only:*

*Antigen Test Result (circle one):* ***POSITIVE*** ***NEGATIVE***

_____ _____

*Testing Support Team Member Signature* *Date & Time*