BSD COVID-19 Consent to Test - Rapid Antigen & PCR

Student Name	
Student Birthdate	
School	
Parent/Guardian Name	
Home Address	
Phone Number	
Email	

In cooperation with the Department of Health and to help limit the spread of COVID-19, the WIAA requires that all athletes and coaches participating in moderate and high contact sports (basketball, wrestling, indoor cheer) undergo twice weekly screening COVID-19 testing for the duration of the season.

Please carefully read the following informed consent notice and sign the authorization to test for COVID-19 for the 21/22 school year.

The COVID-19 tests are shallow nasal swabs, which are quick and painless, and will be self-administered under observation by a trained test administrator.

1. I understand that Rapid Antigen COVID-19 testing of the above-named student will be conducted through an Abbott Laboratories BinaxNOW antigen test provided by the Washington State Department of Health and acknowledge that the BinaxNOW Fact Sheet for Patients for the test has been made available to me BinaxNOW Fact Sheet for Patients.
2. I understand that a PCR COVID-19 test of the above-named student may also be performed to ascertain results of a positive rapid antigen test. A company called Curative will process and analyze the test results.
2. I understand that the ability of the above-named student to receive testing is limited to the availability of test supplies.
3. I understand the entity performing the test is not acting as the above-named student's medical provider. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results, including seeking medical advice, care, and treatment from a medical provider or other health care entity if I have questions or concerns, if the above-named student develops symptoms of COVID-19, or if the above-named student's condition worsens.
4. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
5. I understand it is my responsibility to inform the above-named student's health care provider of a positive test result, and that the patient is responsible for communicating to all close contacts their COVID positive status.
6. I understand that the antigen test result will be available in 15 minutes. If the result is positive, it will be confirmed with a PCR test.
7. I understand and acknowledge that a positive antigen test result is an indication that the above-named student needs to self-isolate to avoid infecting others until the PCR results are received.
8. I understand, per the Washington State Department of Health, a student with COVID-19 or COVID-19 symptoms cannot attend school onsite.
9. 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 test. I understand that if I do not wish for the above-named student to continue with the COVID-19 diagnostic test, I may decline the test.
10. I understand that to ensure public health and safety and to control the spread of COVID-19, the test results may be shared without my individual authorization with the Washington State Department of Health. COVID-19 is a reportable disease and its prevalence is being closely monitored on a community and world-wide level.
11. I understand that the test results will be disclosed to the appropriate public health authorities as required by law.
12. I understand that I may withdraw my consent to the testing at any time before it is performed.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

I consent to authorize the above-named student to undergo COVID-19 testing.

_____ _____

Parent/Guardian Signature Date