East Jackson Consent Form for MDHHS COVID-19 Antigen Testing

First Name: _____ Last Name: _____
Date of Birth: _____ Primary Sport: _____

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

1. **I understand that the MI Safe Schools testing program is a voluntary program offered for student athletes. I understand that testing is an additional tool and does not eliminate the need for other mitigation practices, such as mask use, social distancing and frequent cleaning.**
2. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test, or other acceptable test as ordered by an authorized medical provider or a public health official.
3. I understand that my ability to receive testing is limited to the availability of BinaxNOW test supplies.
4. 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.
5. 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.
6. I understand that my antigen test result will be available in 15-30 minutes. If the result is positive, it will need to be confirmed with a PCR (deep swab) test.
7. I understand and acknowledge that a positive antigen test result is an indication that I need to self-isolate to avoid infecting others until I obtain a negative PCR (deep swab) test result.
8. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have had the opportunity to ask questions before proceeding with a COVID-19 diagnostic test at the school. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test.
9. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without my individual authorization to the appropriate public health authorities, as required by law and state guidelines.
10. I understand that I may withdraw my consent to participate in testing at any time. Notification should be made to Jeff Punches, (517) 764-2090 or by emailing jeff.punches@eastjacksonschools.org.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

☐ I agree to undergo the COVID-19 antigen testing for the duration of the testing period.

_____ ____/_____/_____
Student Signature Date

_____ ____/_____/_____
Parent Signature Date

Completed form should be printed & signed. Bring this with you to your first scheduled testing time.