# **CONSENT FOR TESTING- INDIVIDUAL ADULT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name | | | | | Sex (circle)  Male Female | |  |
| Street Address | | City | | State | | Zip |  |
| Phone Number | Email | | Date of Birth (mm/dd/yyyy) | | | |  |
| Health Care Provider | Phone Number | | Fax Number | | | | |

1. I am the individual seeking BianaxNOW testing.
2. I authorize to conduct BianaxNOW COVID-19 testing on me.
3. I understand that the will release the results of my test **if positive** to the physician or authorized healthcare provider who I designate and to the school nurse assigned to the school in which I work.
4. I understand any test results will be disclosed to county and state health entities as required by law.
5. I acknowledge that a positive test result is an indication that I may be required to isolate to avoid infecting others. Should the test result be positive, I understand I will be contacted by local public health personnel with further instruction.
6. I understand that a patient relationship with is not created by my participating in testing. I understand the personnel administering the testing are not acting as my medical provider.
7. I understand testing does not replace treatment by a medical provider. I will take appropriate action with regards to any test results I receive. I will seek medical advice, care and treatment from my medical provider if my condition worsens.
8. I hereby knowingly and voluntarily consent to have my sample taken and analyzed and I hereby waive any and all rights, claims, or causes of action of any kind for myself, my heirs, executors, administrators, assigns, or personal representatives, and I hereby release and its agents for any injury that I may suffer as a direct or indirect result of participation in this testing activity.

Signature of Testing Recipient Date

Printed Testing Recipient’s Name

|  |  |  |
| --- | --- | --- |
| Test Result: Negative / Positive | Verified by: | Date: |