USD 266 COVID-19 Testing: Information and Informed Consent

USD 266 is working with the Kansas Department of Health and Environment as a pilot site to test USD 266 students and staff for Covid-19. At this time, we are only testing symptomatic people. If you consent, the symptomatic staff member or student (patient) will receive a free diagnostic test for the COVID-19 virus. The test is called the Abbott-BinaxNOW Antigen Test. Collecting a specimen for this test involves inserting a small swab, similar to a Q-tip, approximately one inch into the front of the nose. This test is fairly new, and families may wish to follow up with the more advanced nasopharyngeal, PCR test.

Should the patient test positive and desire a follow-up PCR test, it must be taken within 48 hours. Otherwise the positive test result from the Abbott-BinaxNOW test will be considered final and resulting actions will remain in place.

Should the patient test negative, they cannot return to school/work until symptoms have subsided, including, being fever-free without the use of medication for 24 hours, or until a doctor's release is received.

In the event the patient is subject to a quarantine order for being a close contact of a positive person, a subsequent negative test result will not shorten the quarantine period or required time away from school or work.

Please carefully read and sign the following Informed Consent:

1. I voluntarily consent to USD 266 nursing staff performing COVID-19 testing, using the Abbot-BinaxNOW COVID 19 Ag Card, an antigen test, through a nasal swab as authorized by a medical provider or public health official.
2. I consent to my test results being disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is notice that I must self-isolate, avoid others, and/or remain in my home in compliance with the Sedgwick County Health Department guidelines.
4. I understand USD 266 is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regard to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
5. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
6. I understand that if I receive a positive test and wish to proceed with a polymerase chain reaction (PCR) test, I must be tested within 48 hours. Otherwise, the positive test result from the Abbott-BinaxNOW antigen test will be considered final and resulting actions will remain in place.
7. I understand a negative test will not change the fact that I must remain away from school or work until symptoms have subsided, including, being fever-free without the use of medication for 72 hours, or until a doctor's release is received, nor will it shorten a quarantine period as a close contact of a positive person.

Informed Consent

Patient Name_____ Age _____ Gender _____ D.O.B._____

Symptoms Start Date _____

Symptoms _____

Race (Circle one) Asian – Black - American Indian/Alaskan Native – White – Other – Unknown

Ethnicity (Circle one) Hispanic/Latino – Not Hispanic/Latino - Unknown

Patient Address_____

City_____ State _____ Zip Code_____

Phone _____

Parent/Guardian Name _____

Parent/Guardian Email Address:_____

Patient School: _____

The law allows some information about the staff member or student to be shared with the health department or KDHE. This information will be shared only for public health purposes. Information that may be shared with these agencies includes name and COVID-19 test results, date of birth/age, gender, race/ethnicity, school name(s), teacher(s), classroom/cohort/pod, enrollment and attendance history, and afterschool or other program participation, names of other family members or guardians, address, telephone, mobile number, and email address. Sharing of information will **only** be done so in accordance with applicable law and school policies protecting student and staff member privacy and the security of their data.

I, the undersigned, have been informed about the test purpose and procedures, and have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign this consent and voluntarily agree to this testing for COVID-19.

_____ _____

Patient (18 yrs. or older) or Parent/Guardian Signature Date

Test Administered by _____

Test Date _____ Test Time _____ Test Result _____