

CONSENT FOR TESTING FOR COVID-19 UNDER STANDING ORDER OF PUBLIC HEALTH

Please complete the following information:		
Name:		Date of Birth:
County of Residence:		Phone:
Occupation:	Employer:	
Reason for Testing:		
Please mark any of the symptoms you are currently having:		
Cough	Fever	Sore throat
Shortness of breath	Chills	New loss of taste or smell
Difficulty breathing	Muscle pain	Diarrhea
INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING		
Please carefully read the following informed consent: a. I authorize this COVID-19 testing to be conducted through a nasopharyngeal or nasal swab, as ordered by an authorized medical provider or public health official. b. 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 in my area if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens. c. I understand that a copy of my test results will be sent to me and it is my responsibility to provide a copy to my health care provider if needed. I understand that a copy will not be sent to my health care provider for me. d. I understand that my test results will be disclosed to the appropriate public health authorities as is required by law. e. I acknowledge that a positive test result is an indication that I may need to self-isolate in an effort to avoid infecting others. f. I acknowledge that a negative test result is not a guarantee that I am not currently infected with COVID-19 and may still need to be in isolation or quarantine. I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19. AGREEMENT FOR SELF-ISOLATION If I am found to have COVID-19, it may be necessary to be placed in isolation in order to prevent the transmission of this infection to others. It is important for me to comply with this Isolation Agreement in order to protect the public's health and prevent further outbreaks of COVID-19. a. I understand that if I am infected with the virus causing COVID-19, I may meet criteria for isolation. b. I agree that if I currently have symptoms of COVID-19, I will remain in home self-isolation while I await my COVID-19 test results. c. I agree that if my COVID-19 test results are positive, I will remain in home self-isolation until the date the health department deems it safe to be completed. d. I agree that if my COVID-19 test results are negative, yet I have symptoms of COVID-19, I will remain in home self-isolation until the date the health department deems it safe to be completed. e. I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons and may be in violation of public health laws. I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19 and to any required self-isolation that may result.		
_____ Signature of patient/guardian/custodian		_____ Date