**Dearborn Public Schools**

**Middle School Athletics**

**Consent Form - Rapid COVID-19 Antigen Test**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please carefully read the following informed consent:**

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

1. 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.

1. I understand that my ability to receive testing is limited to the availability of test supplies.
2. I understand that I am not creating a patient relationship with the school district 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.

1. 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.
2. 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 test. I also understand that a positive test will require me to immediately leave the school area and not return until I’ve followed the proper protocol for Covid-19 return to school.
3. 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 test result.
4. 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 diagnostic test at the testing site. I understand

that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test. **If I decline to test, I may not participate in athletic practice or competition.**

1. 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.

1. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
2. **I understand that I may withdraw my consent to participate in testing at any time, and that doing so will forfeit my right to participate in the MI Safer Sports program.**

**AUTHORIZATION/CONSENT TO TEST FOR COVID-19**

* I agree to undergo the COVID-19 antigen testing for the duration of the testing period/ authorize my child to undergo testing throughout the school year, ending June 18, 2021.

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Patient/Parent/Legal Guardian Signature Date