PIERCE COUNTY MASS TESTING CONSENT FOR TESTING & DEMOGRAPHICS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of test site: | | | | | |
| Do any of the following apply to you? | Student | Faculty | Resident | Employee | Other/  Not applicable |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | | | | Date of Birth: | |
| Email: | | | | Cell Phone: | |
| Address: | | | | Zip Code: | |
| City: | | | | State: | |
| Preferred Language  (Circle one) | | English | Spanish | | Russian |
| Korean | Vietnamese | | German |
| Tagalog | Other: | | |
| Check all that apply | Race | | Check all that apply | Ethnicity | |
|  | American Indian or Alaska Native | |  | Hispanic or Latino | |
|  | Black/African American | |  | Not Hispanic or Latino | |
|  | Native Hawaiian or Pacific Islander | |  |  | |
|  | Asian | |  |  | |
|  | White | |  |  | |
|  | Other Race | |  |  | |

**Consent for Testing:**❑ **By checking the box, I agree to a text message and/or email communication to receive my COVID-19 test results. (Only negative results will come via text or email. Positive tests will result in a phone call to the number listed above).**

I authorize DispatchHealth to conduct collection and testing for COVID-19 through an anterior, mid-turbinate swab as ordered by a licensed medical professional.

I authorize my test results to be disclosed to the county, state, ‘covered entity’ or to any other governmental agency as may be required by law.

I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed to avoid infecting others.

I understand the testing unit is not acting as my medical provider, this test does not replace treatment by my medical provider, and I assume complete and full responsibility to take the appropriate action with regards 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 medical condition worsens.

I understand that, as with any medical test, there is the potential for a false positive (**test is positive but I do not have the infection**) or false negative (**test is negative but I do have the infection**) COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks, and I can request 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 additional questions at any time. I voluntarily agree to this testing for COVID-19.

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_