Affix unique test barcode here

COVID-19 Screening Participant Information & Consent Form

Participant Information

Last Name	First Name	MI

Date of Birth	Gender	Race		Ethnicity
(MM/DD/YYYY)	☐ Male ☐ Female ☐ Other ☐ Unknown ☐ Ambiguous	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ☐ Unknown	☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Participant Contact Information

Cell Phone	( ) _____ - _____	**Email Address**	
Street Address		**County**	
City		**State**	**Zip Code**

Participant Consent for Testing

COVID-19 RT-PCR Testing will be performed by a laboratory certified under the Clinical Laboratory Improvement Amendments (CLIA) to perform high-complexity testing and is performed in accordance with the Policy for Coronavirus Disease-2019 Tests During the Public Health Emergency.

This testing is intended for screening of asymptomatic persons with no known close contact exposure to COVID-19 and does not require a physician order to perform.

Informed Consent for Testing:

- I authorize the collection of a nasal swab sample for use in COVID-19 RT-PCR testing by the above referenced laboratory.
- I understand my results are **NOT for Diagnostic Use**. The results are intended for information use for the purpose of detecting transmission risks and hot spots.
- I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.
- I acknowledge that a positive test result is an indication that I should follow Centers for Disease Control (CDC) guidelines and may need to self-isolate to avoid infecting others.
- I authorize my test results and demographic information to be disclosed to the organization facilitating my participation in this COVID-19 screening as well as to the county, state, or any other governmental entity as may be required by law.
- I understand that I am not creating a patient relationship with the testing facility and that testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action including seeking medical advice, care, and treatment from my medical provider if I have questions about my test results.
- I understand that if I am an age eligible to donate plasma and my results are positive for COVID-19, I give my authorization to be contacted for a referral to donate COVID-19 Convalescent Plasma.
- I acknowledge my test result report will include further information on the test results interpretation in accordance disclosures required by the Food and Drug Administration (FDA).
- I acknowledge that by signing, I am not exhibiting any of the following symptoms: New loss of taste or smell, fever, chills, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.

I, the undersigned, voluntarily agree to this testing for COVID-19 and understand this consent will remain on file and in effect for subsequent periodic screening tests until I withdrawal this consent, or this consent is superseded by a new consent. I also consent the laboratory to contacting my by phone to discuss my results directly with me, if necessary.

Screening Participant ***(Signature)***	☐ Check Box if Under 18 Years (and provide parental consent)	**Date**	____/____/_____

Parental Consent

Parental Consent (for participants under 18 years of age)

I agree that the person named above will receive the tests indicated to screen for COVID-19. I have had a chance to ask questions about the sample collections process. I affirm that I am an adult who can legally consent for the person named above to get screened for COVID-19. I freely and voluntarily give my signed permission for these screening tests to be given.

I authorize the release of information to the organization facilitating the COVID-19 testing as well as county, state, or any other governmental entity as may be required by law, as well as the San Antonio Metropolitan Health District.
I, agree to this testing for COVID-19 and understand this consent will remain on file and in effect for subsequent periodic screening tests until I withdrawal this consent, or this consent is superseded by a new consent.

Parent/Guardian ***(Signature)***		**Date**	____/____/_____