



Lansing School District

2023 – 2024

Consent and Registration Form for Rapid MULTIPLEX COVID-19 and Influenza Antigen Test

Child Full Name: _____

DOB: _____

School: _____

Please carefully read the following notice and sign the authorization to test for COVID-19 and Influenza:

1. I understand that the COVID-19 and Influenza testing will be conducted through a MULTIPLEX antigen test, or other acceptable test as ordered by an authorized medical provider or public health official.
2. I understand that my ability to receive testing is limited to availability of test supplies.
3. 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 if I have questions or concerns, if I develop symptoms of COVID-19/Influenza, or if my condition worsens.
4. 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.
5. I understand that my antigen test result will be available in 15-30 minutes.
6. I understand and acknowledge that a positive antigen test result for COVID-19 and/or Influenza is an indication that I need to self-isolate to avoid infecting others.
7. 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 MULTIPLEX diagnostic test at the testing site. I understand that if I do not wish to continue with the MULTIPLEX diagnostic test, I may decline to test.
8. I understand that to ensure public health and safety and to control the spread of COVID-19 and Influenza, my test results may be shared without my individual authorization.
9. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
10. I understand that I may withdraw my consent to participate in testing at any time.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19 AND INFLUENZA

I agree to undergo the COVID-19 and Influenza antigen testing for the 2023-24 school year, and authorize my child to undergo testing.

Parent Signature: _____ Date: _____