CONSENT FOR BINAX NOW TESTING

FIRST NAME: _____ **MIDDLE INITIAL** _____ **LAST NAME**: _____

DATE OF BIRTH: _____/_____/_____ **SEX:** Male / Female / Other
(mm) (dd) (yyyy)

ETHNICITY: Hispanic / Non- Hispanic **RACE:** White / African American or Black / Native American / Asian-Pacific Islander / Other / Unknown

MAILING ADDRESS: _____
House # and street name, apt # city state zip code

TELEPHONE NUMBER: (_____) _____-_____

SYMPTOMS: Cough / Fever / Shortness of Breath/ Sore Throat/ Loss of Taste or Smell / Vomiting
New Moderate-Severe Headache / Possible Exposure

TESTING ORGANIZATION: Bradley-Bourbonnais Community High School

In consideration for receiving the opportunity to participate in **COVID-19 testing** (hereinafter "Testing"), which is provided by Bradley-Bourbonnais Community High School, I hereby release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes Company and their healthcare staff, members, shareholders, officers, servants, agents, volunteers, or employees (herein referred to as "Indemnitees") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in Testing, while traveling to and from the Testing, or while on the premises owned or leased by Indemnitees.

I am fully aware that the Testing provided by the organization may involve COVID-19 tests that have not gone through a full FDA approval process and instead obtained emergency use authorization (EUA) or registered and are pending such processing and that the results could produce false positives or false negatives, or be administered in a way that otherwise produces inaccurate results. I am also fully aware that the organization is not providing medical care or giving a medical diagnosis with Testing and that ***I should consult my doctor or go to an emergency room if I have any serious symptoms and/or to obtain medical advice from my own doctor as to the results of the Testing***.

I hereby waive my rights regarding protected health information under HIPAA, to the extent necessary to complete the Testing and to allow the organization to provide the results (whether positive or negative) of Testing to (1) the organization which has arranged for the testing, and (2) local and state public health authorities (which may result in further direct communication from those entities to me for further follow-up and contact tracing). Protected health information will not be reused or disclosed by the organization to any person or entity other than above, except as required by law.

By signing below, I am agreeing to voluntarily testing. In signing this agreement, I acknowledge and represent that I have read it, understand it, and sign it voluntarily. Consent will be valid for one year after the date signed unless otherwise written or if a written discontinuation request is provided after being signed.

Signature: _____ **Date**: _____
(If Participant is under 18 years old, please have Parent or Legal Guardian Sign)

Parent/ Legal Guardian Signature: _____ **Date**: _____