



COVID-19 Antigen Test Consent

I understand that the intent of this test is to determine whether I have a current COVID-19 infection. I understand that this test has been authorized by FDA under an EUA for use by authorized laboratories during this public health emergency for the detection of proteins from the SARS-CoV-2 virus that causes COVID-19, however, it has not been cleared or approved by the FDA.

I understand that the test has potential risks associated with it, such as possible discomfort or other complications that may occur during sample collection and possible incorrect test results.

While my results are pending, I understand that I need to comply with all FDA and CDC guidelines regarding isolation and/or quarantine. Once I receive my results, I understand that I need to discuss them with my healthcare provider for further guidance on what is necessary before I may return to normal activities, which may include additional isolation and/or follow-up testing.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE ACKNOWLEDGEMENT AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS. BY SIGNING BELOW, I CONSENT TO UNDERGO THE COLLECTION AND LABORATORY TESTING FOR THE ANTIGEN TEST UNDER THE CONDITIONS SET FORTH HEREIN

Date: ____ - ____ - ____

Client Signature (or Legal Guardian)

Printed Name

Relationship if signing on behalf of the client