DISTRICT EMPLOYEES

COVID-19 BinaxNOW Antigen Testing Consent Form

And Waiver and Release of Claims

Dear Employee:

If you have symptoms of COVID-19, you may choose to voluntarily receive a nasal swab BinaxNOW antigen test to detect whether you may have COVID-19. Symptoms may include: cough, fever, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea. If you would like to receive the BinaxNOW antigen test if/when you begin showing symptoms of COVID-19, please complete the following information:

Name: _____ DOB: _____

Email: _____ Phone: _____

Address with City/Zip: _____

Assigned School/Position: _____

Other Vail staff or students in household (if applicable, list first/last name and school):

_____

(Initial each line separately. Every line must be initialed for consent to be valid):

a. _____ I authorize the COVID testing trained personnel to administer the COVID-19 BinaxNOW antigen test to me.

b. _____ I understand that the test result will be disclosed to county and state health officials and designated school officials.

c. _____ I understand that there is the potential for a false positive or false negative COVID-19 test result.

d. _____ I acknowledge that I have received and/or can obtain a fact sheet about the BinaxNOW antigen test at the following link: https://www.fda.gov/media/141569/download

e. _____ I have been informed that a negative test will not necessarily rule out infection or COVID-19 and I am still required to follow the Vail School District procedures for symptoms consistent with COVID-19.

Waiver of Liability and Release of Claims:

In providing my consent for the District to administer the BinaxNOW antigen test to me, and to the fullest extent permitted by law, I hereby agree to waive, release, and discharge any and all claims, causes of action, damages, and rights of any kind against the District, its insurers, the District's Governing Board, and all of their respective employees, agents, representatives, and volunteers (the "Released Parties") arising from or relating in any way to any damage, injury, trauma, illness, loss, disability, or death that may occur to me, or my household members as a result of the test administration or a false negative/false positive test result from the District's administration of the COVID-19 BinaxNOW antigen test given to me.

I further agree not to sue the Release Parties, and to defend and indemnify the Release Parties for all claims, damagers, losses, or expenses, including attorney's fees, if a lawsuit is filed concerning an injury, illness, or death to me, or my household members as a result of the test administration or a false negative/positive test result from the District's administration of the COVID-19 BinaxNOW antigen test given to me.

BY MY SIGNATURE BELOW, I AGREE TO THE ADMINISTRATION OF THE COVID-19 BINAXNOW ANTIGEN TEST BY TRAINED DISTRICT PERSONNEL

Employee Name (Printed): _____

Employee Signature: _____

Date: _____

This Consent Form must be completed prior to any employee receiving the antigen testing during the course of his/her employment. This Consent Form is only valid during the 2020-2021 school year, ending June 30, 2021.

DISTRICT USE

TEST RESULTS

____NEGATIVE ____POSITIVE

Date and time of test: _____

Administered by: _____