NON-STUDENT/FAMILY MEMBER

COVID-19 BinaxNOW Antigen Testing Consent Form

And Waiver and Release of Claims

You or your household member may be eligible to receive a nasal swab BinaxNOW antigen test if you/they is/are showing symptoms of 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 or your household member would like to receive the BinaxNOW antigen test, please complete the following information:

Name: _____ DOB: _____

Email: _____ Phone: _____

Address with City/Zip: _____

Parent/Guardian name (if applicable): _____

Parent/Guardian name (if applicable): _____

Vail School District worksite (if applicable): _____

School attending/grade (if applicable): _____

Relationship to Vail staff or student (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 Vail School District trained personnel to administer the COVID-19 BinaxNOW antigen test to me or my minor aged family member.

b. _____ I understand that all test results 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. _____ If I or my minor aged family member has/have symptoms, I have been informed that a negative test will not necessarily rule out infection or COVID-19 and we will still be required to follow 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 my child, 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 my child, 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 to my child.

I further agree not to sue the Release Parties, and to defend and indemnify the Release Parties for all claims, damages, losses, or expenses, including attorney's fees, if a lawsuit is filed concerning an injury, illness, or death to me, my child, 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 my child.

BY MY SIGNATURE BELOW, I AGREE TO THE ADMINISTRATION OF THE COVID-19 BINAXNOW ANTIGEN TEST BY DISTRICT PERSONNEL TO BE PROVIDED TO ME OR MY MINOR AGED FAMILY MEMBER.

Adult/Parent/Guardian Name (Printed): _____

Adult/Parent/Guardian Signature: _____

Date: _____

Review the BinaxNOW Fact Sheet here:
https://www.fda/gov/media/141569/download

This Consent Form must be completed prior to any antigen testing. This Consent Form is only valid during the 2020-2021 school year, through June 30, 2021.

DISTRICT USE

TEST RESULTS

_____ NEGATIVE _____ POSITIVE

Date and time of test: _____

Administered by: _____