|  |  |
| --- | --- |
| Full Name of Child Child Date of Birth (mm/dd/yy) | Sex of Child (circle)Male Female |
| Street Address | City | State | Zip |
| Parent Phone Number |  Do you want to receive results via text message (circle) **YES NO** | Date of First Symptom: |

1. I am the:  parent; or  legal guardian of the individual named above who is seeking BianaxNOW testing.
2. I authorize Helena School District No. 1 to conduct BinaxNOW COVID-19 testing on the individual named above, who is my child or legal ward.
3. I understand that the Helena School District will release the results of my child or legal ward’s test **if positive** to the physician or authorized healthcare provider who I designate.
4. I understand any test results will be disclosed to county and state health entities as required by law.
5. I acknowledge that a positive test result is an indication that my ward may be required to isolate to avoid infecting others. Should the test result be positive, I understand I will be contacted by local public health personnel with further instruction.
6. I understand that a patient relationship with Helena School District No. 1 is not created by my child or legal ward’s participating in testing. I understand the Helena School District personnel administering the testing are not acting as my child or legal ward’s medical provider.
7. I understand testing does not replace treatment by a medical provider. I will take appropriate action with regards to any test results I receive. I will seek medical advice, care and treatments from my child or legal ward’s medical provider if my child or legal ward’s condition worsens.
8. I hereby knowingly and voluntarily consent to have my child or legal ward’s sample taken and analyzed and I hereby waive any and all rights, claims, or causes of action of any kind for myself, my child, my ward, my heirs, executors, administrators, assigns, or personal representatives, and I hereby release Helena School District No. 1 and its agents for any injury that my child or legal ward may suffer as a direct or indirect result of participation in this testing activity.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent or Guardian** **Date**

## **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## **Printed Parent or Guardian’s Name**

|  |  |  |  |
| --- | --- | --- | --- |
| Test Result: Negative / Positive | Verified by: | Date: | Time: |

**SEE BACK FOR ADDITIONAL QUESTIONS**

Demographics

This information is collected as part of public health efforts to recognize and address inequality in health outcomes.

1. Race
* American Indian/Alaskan Native
* Asian
* Black/African American
* Native Hawaiian/other Pacific Islander
* White
* Other
* Prefer not to answer
1. Tribal affiliation, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you Hispanic or Latino?
* Yes
* No
* Prefer not to answer
1. Sex assigned at birth
* Female
* Male
* Other
* Prefer not to answer
* Other
1. Are you a resident in a congregate living setting? For example: nursing home, group home, prison, jail, or military
* Yes
* No
* Unknown
1. Are you a health care worker?
* Yes
* No
* UnknownTop of Form
1. Are you currently pregnant?
* Yes
* No
* Prefer not to answer
1. Are you experiencing any of the following symptoms?
* No symptoms
* What are your symptoms (circle all that apply)?

|  |  |  |  |
| --- | --- | --- | --- |
| Fever over 100.4F | Shortness of breath | New loss of taste | Runny nose |
| Feeling feverish | Difficulty breathing | New loss of smell | Nausea |
| Chills | Fatigue | Sore throat |  |
| Cough | Headache | Nasal congestion |  |
| Vomiting | Diarrhea | Muscle or body aches |  |