Outpatient COVID Rapid Testing Consent

In the last 10 days has your child had a: (please circle)

1) Fever, chills, cough, runny nose, congestion, or sore throat? YES NO
2) Fatigue, headache, muscle or body ache, vomiting, or diarrhea? YES NO
3) New loss of taste or smell? YES NO
4) Been diagnosed with COVID or had a positive COVID test? YES NO
    - If YES, when: _____

1) I voluntarily consent and authorize South East Bay Pediatric Medical Group (SEBPMG) to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test for my child. I acknowledge and understand that this COVID-19 diagnostic test will require the collection of an appropriate sample by my healthcare provider through a nasal swab, nasopharyngeal swab, oral swab, or other recommended collection procedure. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to the test results. Should I have questions or concerns regarding the results, I shall promptly seek advice and treatment for my child.
2) I acknowledge and agree that SEBPMG may disclose the test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.
3) I acknowledge that SEBPMG will be billing my insurance for the cost of COVID testing. I acknowledge that any service not covered by my plan is my responsibility. I acknowledge that it is my responsibility to be aware of any requirements imposed by my insurance company related to COVID testing services.
4) To the fullest extent permitted by law, I hereby release, discharge and hold harmless, SEBPMG, including, without limitation, any of its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.
5) I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

Patient: _____ DOB: _____

Signed by: _____ Date: _____

Name: _____

Relation to patient (circle one): mother father legal guardian patient (>18 years)