Patient Name:_____ WIN:_____

Informed Consent for COVID-19 Antigen Testing

- I authorize WMU Sindecuse Health Center to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider.
- I authorize my test results to be disclosed to the county, state, or to any of my close contacts.
- If a student, I authorize a positive test result to be disclosed to the Dean of Students and my instructors for in-person classes so they may provide academic support as may be necessary. Your results will remain confidential and no other personal health information will be shared. **There are no consequences if I decline to provide this consent.** If I decline, I acknowledge that the Dean of Students will receive notification that I will be absent from class, but this notification will not include my diagnosis.
- If an employee, I authorize a positive test result to be disclosed to my immediate supervisor so they may facilitate time off and/or other safety precautions. Your results will remain confidential and no other personal health information will be shared.
- I acknowledge that a positive antigen test result is an indication that I must continue to self-isolate in an effort to avoid infecting others. A positive test may result in extended quarantine and additional tests.
- I understand that testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care, and treatment from a medical provider if I have questions or concerns or if my condition worsens.
- I understand that medical treatment before/during/after my testing may result in the following: hospitalization that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.
- I understand that COVID-19 may cause additional risks, some or many of which may not currently be known.
- I understand that, as with any medical test, there is the potential for false positive or false negative test results. I also understand that I may be exposed to or contract COVID-19 after this sample is taken, resulting in a future positive test or symptoms of disease.
- I understand that there will be a cost associated with COVID-19 testing. These costs include $35 to $135 for a clinical visit (in person or via telehealth) to evaluate my condition and $50 for the COVID-19 laboratory test. WMU will bill medical insurance first if it is provided; any remaining balance after insurance is my responsibility. If the test is not medically necessary, I waive the right to use my insurance and will be responsible for all charges associated with this visit and test.
- I recognize that Western Michigan University and all the staff at Sindecuse Health Center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19.
- I, the undersigned, have been informed about the test purpose, procedures, cost, possible benefits and risks, and I have received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to receive the COVID-19 test.

_____

Signature of Patient/Date

_____

Witness/Date