EASTERN WASHINGTON UNIVERSITY COVID-19 TEST FORM

Abbott BinaxNOW COVID-19 Ag CARD

COLLECTION DATE	TEST RESULT ☐ Positive ☐ Negative ☐ Invalid

Patient Information

PATIENT'S NAME (Last name, First Name, Middle Initial)		STATUS ☐ EWU Student ☐ EWU Employee
SEX ☐ Female ☐ Male	DATE OF BIRTH	PHONE
LOCAL ADDRESS	CITY	STATE ZIP
EMAIL	STUDENT ID or EWU ID	

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

RACE (select all that apply)

- ☐ Black
- ☐ White
- ☐ Asian
- ☐ American Indian / Alaskan Native
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other (specify): _____

EWU COVID-19 Antigen Testing Informed Consent and Authorization

Please read carefully and sign the following informed consent and authorization.

1. I authorize Eastern Washington University to provide the Abbot BinaxNOW COVID-19 Antigen Test to me.
2. I authorize Eastern Washington University to collect my test results for public health purposes, to include contact tracing, and to disclose the results to public health authorities as required by law.
3. I acknowledge that a positive test is an indication that I must self-isolate in accordance with all EWU current COVID-19 protocols and the instructions of EWU Health and Wellness staff, EWU Human Resources and/or the Spokane Regional Health District (SRHD).
4. I understand that Eastern Washington University is not acting as my medical provider and this test does not replace or substitute treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results and I agree I will seek medical advice, care, and treatment from my medical provider if I have questions, concerns, or my condition worsens.
5. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I understand and have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

_____

Signature **Date**