QDxPath

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COVID-19 Student Testing Consent Form

I authorize specimen collection for testing to determine if I may have a current infection or past infection of SARS-CoV2, the virus that causes COVID-19. I further understand, agree, certify, and authorize the following:

1. I understand that my Camp, has contracted with a **QDx Pathology Services, Inc.** for collection of my specimen.
2. I authorize that Laboratory to collect the specimen.
3. I have the right to refuse testing.
4. My Camp has contracted with **QDx Pathology Services, Inc.,** for analysis and reporting of my specimen. I authorize **QDx Pathology Services, Inc.** to perform testing on my specimen.
5. I understand that processing of the specimen and results may take between 24-48 hours.
6. **QDx Pathology Services, Inc.** will provide communication of the test results to my camp. I authorize **QDx Pathology Services, Inc**., to release test results or other information necessary to my Camp the ordering physician, and to me.
7. I acknowledge that this procedure and the results are not a substitute for medical advice or treatment from my personal health care provider. I will consult with and obtain care from a health care provider regarding the results of this test. I understand that **QDx Pathology Services,** cannot offer advice regarding interpretation of these results and I must obtain interpretation and recommendations from a health care provider.
8. I understand that the **QDx Pathology Services, Inc.** has infectious disease reporting responsibilities under applicable governmental regulations and will report my testing information in accordance with these regulations.

By checking the box, I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree that my results can be released to my school.

Student

_____	_____	_____
Signature	Printed Name	Date

Guardian

_____	_____	_____
Signature	Printed Name	Date