Rogers City Area Schools
Registration Form for Voluntary Rapid COVID-19 Antigen Test

Testing Facility: _____

Address: _____

Phone:_____ Organization: _____

Testing Date: _____

Personal Information (of person being tested)

First Name: _____ Last Name: _____ Middle: _____

Phone Number: ( ) - _____ - _____ Email Address: _____

DOB: (mm/dd/yyyy) ____ /____ / _____ Biological Sex: * Male * Female * Prefer not to answer

Street Address: _____

City/State/Zip: _____

Race: Please check the box next to the one that best describes your/your child's race.

- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Asian
- ☐ White/Caucasian
- ☐ Hawaiian/ Pacific Islander
- ☐ Other
- ☐ Unknown or Decline to specify

Hispanic or Latino: Please check the box next to one of the following that best describes your/your child's ethnicity.

- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic
- ☐ Unknown or Decline to specify

Arab or Middle Eastern: Please check the box next to one of the following that best describes your/your child's ethnicity.

- ☐ Arab or Middle Eastern
- ☐ Not Arab or Middle Eastern
- ☐ Unknown or Decline to specify

Do you have symptoms related to COVID-19? ☐ Yes ☐ No ☐ Unknown

If yes, what is the date the symptoms started? _____

**Have your insurance information ready in case antigen test is negative and saliva PCR test is indicated. For those without insurance, no-cost test state-run test sites are available.*

Consent Form for Voluntary Rapid COVID-19 Antigen Test

First Name: _____ Last Name: _____
DOB: _____
School District: _____
School Building: _____

Please carefully read the following informed consent and sign the authorization to test for COVID-19:

1. I consent to participating in or authorize my child to participate in voluntary COVID-19 testing through the Michigan Department of Health and Human Services MI Safe School Testing Program, in which testing will be administered by authorized School District staff. I am knowingly assuming and accepting the risks associated with the testing program on my behalf or on my child's behalf.
2. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test, or other acceptable test as ordered by an authorized medical provider or a public health official.
3. I understand that my/my child's ability to receive testing is limited to the availability of test supplies.
4. I understand that I am not creating a patient relationship with the ordering physician by participating in this testing. I understand that neither the School District nor its employees, officers, or agents are acting as my/my child's medical provider. Testing does not replace treatment by my/my child's medical provider. I assume complete and full responsibility to take appropriate action with regards to my/my child's test results and my/my child's medical care. I agree I will seek medical advice, care, and treatment from my medical provider or other health care entity if I have questions or concerns, if I or my child develop symptoms of COVID-19, or if my/my child's condition worsens.
5. I understand it is my responsibility to inform my/my child's health care provider of a positive test result, and that a copy will not be sent to my/my child's health care provider for me.
6. I understand that my/my child's antigen test result will be available in 15-30 minutes. If the result is positive, it will need to be confirmed with a PCR test.
7. I understand and acknowledge that a positive antigen test result is an indication that I/my child need(s) to self-isolate to avoid infecting others until I/my child obtain a negative PCR test result.
8. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 diagnostic test at the testing site. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test.
9. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results, which will be retained by an appropriate schools administrator, will be disclosed to the appropriate public health authorities as required by law. I consent to that disclosure under applicable state and federal law and regulations, including but not limited to the Family Educational Rights and Privacy Act ("FERPA") and/or the Americans with Disabilities Act ("ADA").
10. If I disclosed demographic information about myself/my child on this form or the Registration Form for Voluntary Rapid COVID-19 Antigen Test, I consent to the disclosure of that demographic information under applicable state and federal law and regulations, including but not limited to the FERPA and the ADA.
11. I understand that participation in the COVID-19 rapid testing program is wholly voluntary and that I may withdraw my consent to participate or authorization and consent for my child to participate in testing at any time.
12. I shall indemnify and hold harmless the School District listed above and its Board or Education members, employees, and agents from any and all causes of action, claims, demands, losses, costs, damages, and expenses of any nature arising out of or in any way related to my participation in the COVID-19 testing.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

☐ I agree or authorize my child to undergo COVID-19 antigen testing through the Michigan Department of Health and Human Services MI Safe School Testing Program, which testing will be administered by authorized School District staff, and I agree to all the terms above.

_____ _____

Patient/Parent/Legal Guardian Signature Date

MI Safer Sports COVID-19 Testing Program: Participant Code of Conduct

The Michigan Department of Health and Human Services is pleased to provide COVID-19 rapid antigen tests for all athletics. All participants must be tested consistent with MDHHS Interim Guidance for Athletics issued on March 20, 2021.

As a participant in the MI Safer Sports program, I understand and agree to the following:

- My participation in the practices and competitions over the course of this program is voluntary.
- I have reviewed and will comply with the additional mitigation measured outlined in the MDHHS Interim Guidance for Athletics.
- I agree to receive a COVID-19 test (rapid test) at the cadence prescribed in the MDHHS Interim Guidance for Athletics.
    - If I test positive, I understand that I cannot return to practice or compete unless I receive a negative molecular (PCR) test within 48 hours of the rapid test results and I continue to have no symptoms.
- If I exhibit any symptoms of COVID-19, I will self-isolate and not attend practice or competition, regardless of any negative test result.
- If I test positive for COVID-19, show symptoms, or am exposed in close contact to someone who tests positive, I will cooperate with local and state public health officials in the case investigation and contact tracing process.
- Inside and outside of practice and competition, I will follow all state and local health orders that apply in my area, including wearing a face mask when around others, limitations on gatherings outside my immediate household, including non-team gatherings and social gatherings with my team outside of practice or competition.

I understand that failure to follow the above agreements could result in my removal from competition and practices and may result in disqualification of my entire team.

MDHHS may request documentation at any time necessary to enforce this Code of Conduct.

_____ _____

Participant Signature & Date

_____ _____

Parent/Guardian Signature & Date if Participant is a Minor