Today's Date:_____

Jasper County Health Department

Authorization and Informed Consent

1. Please PRINT the following information:

Patient Name:		Date of Birth:
Address:		City, State, Zip:
Sex : M F	Hispanic: Y N	Race:
County of Residence:		Phone #:
Doctor:		Result:

Nurses Signature: ----------

2. Do you live in a group home, assisted living center or other facility with more than 3 other people older than 60 years old? ☐ YES ☐ NO

3. Do you work in a hospital, long-term care facility or assisted living facility? ☐ YES ☐ NO

4. Have you traveled anywhere outside of Illinois in the past 1 month? ☐ YES ☐ NO

   If YES, please state locations _____

5. Have you been in close contact (i.e. within 6 feet) with someone confirmed to have COVID-19?

   ☐ YES ☐ NO

   If YES, please state locations _____

6. Have you received the covid vaccine? ☐ YES ☐ NO

   If Yes, date of vaccine(s) _____

7: Have you previously tested positive for covid? ☐ YES ☐ NO

   If Yes, date(s):----------

TESTING ELIGIBILITY

COVID-19 diagnostic testing, authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA), will be used today.

Please mark any symptoms you are currently experiencing:

☐ Fever	☐ Cough	☐ Diarrhea
☐ Muscle Aches	☐ Nausea or vomiting	☐ Tiredness
☐ Headache	☐ Shortness of Breath	☐ Sore Throat

☐ Other: _____

Onset of symptom(s) date: _____

AUTHORIZATION AND INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

8. Please carefully read the following informed consent:

I voluntarily consent and authorize Jasper County Health Department (JCHD) to conduct collection, testing and analysis for the purposes of a COVID-19 diagnostic test.

I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample using a nasal swab, as ordered by an authorized medical provider or public health official.

I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.

I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my 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 my medical provider if I have questions or concerns, or if my condition worsens.

I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

I, the undersigned, have been informed about the test purpose, procedures, 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 testing for COVID-19.

PATIENT RIGHTS AND PRIVACY PRACTIICES

Disclosure to Government Authorities: I acknowledge and agree that JCHD may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

RELEASE

To the fullest extent permitted by law, I hereby release, discharge and hold harmless, including, without limitation, any 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 test results.

AGREEMENT FOR SELF-ISOLATION

The local health jurisdiction has determined that if you are under suspicion for having COVID-19 due to symptoms and testing request, that it is necessary to be placed in isolation in order to prevent the transmission of this infection. It is important for you to comply with this Isolation Agreement in order to protect the public's health. Thank you for agreeing to cooperate.

9. Please carefully read and comply with the following statements:

   I understand that I may be infected with the virus causing COVID-19 and that I meet criteria for isolation.

   I agree that while I wait for my COVID-19 test results, I will remain in self-isolation.

   I agree that if my COVID-19 test results are positive, I will remain isolated for 10 days from this day of testing OR until at least 10 days after my symptoms onset **AND**

   I agree I will stay on isolation until my symptoms have decreased **AND** I have been fever free for greater than 24 hours.

   I agree that if my COVID-19 test results are negative, I will remain isolated until at least 72 hours after my symptoms have resolved.

   I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.

   I agree that I will not come into contact with any other person who is not isolated or ill due to potential COVID19 infection.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. By selecting the ACKNOWLEDGEMENT during the registration process for COVID-19 Diagnostic Testing by JCHD, 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. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test., and I have been told that I can ask other questions at any time. 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. I have read the contents of this form in its entirety, and I voluntarily consent to undergo diagnostic testing for COVID-19.

Signature of patient/guardian (if patient is under 18) **Date**

Relationship to Patient:

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