COVID Registration Number

_____

COVID-19 Testing: Informed Consent

Please carefully read and sign the following Informed Consent:

1. I authorize this COVID-19 testing unit, Bluewater Toxicology, LLC d/b/a Bluewater Diagnostic Laboratory (hereinafter referred to as "Bluewater"), to conduct collection and testing for COVID-19 through a nasopharyngeal swab, oral swab, or other recommended collection procedure on me or my minor dependent.
2. I authorize these test results be disclosed to _____, to county and state public health departments, and to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that self-isolation is required in an effort to avoid infecting others.
4. I understand Bluewater is not acting as a medical provider, this testing does not replace treatment by a medical provider, and I assume complete and full responsibility to take appropriate action with regards to these 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 or my minor dependent's 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.
6. I have been made aware that Bluewater's Patient Privacy Notice is available for review at: https://bluewaterdxlab.com/patient-privacy-policy/

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. 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 additional questions at any time. I voluntarily agree to this testing for COVID-19 for me or my minor dependent. Please check the appropriate box regarding the patient:

☐ Student ☐ Employee ☐ Faculty ☐ Other – _____

_____ _____

Patient First Name Patient Last Name

_____ _____

Signature of Employee, Staff or Student Date

_____	_____
Signature of Guardian (*if patient is under 18 years of age*)	Relationship to Patient
_____	_____
Date	Date
_____	_____
Address (street address, city, state, zip)	Phone number
_____	_____
Patient's sex, race	ethnicity
_____	_____
Name of Participating School and District	School address (street address, city, state, zip)
_____	
School phone number	