Pampa Independent School District BinaxNOW Staff Consent Form

BinaxNOW is an antigen test that detects the presence of the SARS-CoV-2, which is the virus that causes a COVID-19 infection, in about fifteen (15) minutes. The specimen for the test is collected via nasal swab. This test is completely voluntary and will not ever be administered unless this form is signed.

A positive result of this test will be immediately reported to the Gray County Health Director, Department of State Health Services (DSHS), and Texas Department of Emergency Management (TDEM) per our required guidance so that it can begin contact tracing and instituting appropriate disease control measures. Additionally, all test results will be shared with the Texas Education Agency (TEA) pursuant to state regulation.

BinaxNOW is currently only able to be administered to individuals suffering from symptoms consistent with an infection of COVID-19. A negative test result, however, may indicate that those symptoms are actually the result of a common cold, allergies, or a different illness. If symptoms consistent with an infection of COVID-19 develop or persist after a negative test result, consult with a health care provider to determine the best course of action. Pampa ISD current protocols state that if an individual has symptoms consistent with COVID that they may return to school after a 10-day isolation, a negative COVID test or an alternative diagnosis from a physician.

Except as required by law, test results and testing information will be kept confidential by the school district, DSHS, TEA and TDEM. Completing and signing this form serves as consent for the test to be performed on the named individual and is also an acknowledgment of the above statements as well as the content of the enclosed notice entitled "School Reporting of a Positive or Suspected COVID-19 Student or Employee." Upon request, this completed and signed form should be provided to the appropriate school district personnel.

STAFF CONSENT AND ACKNOWLEDGEMENT

Name of Person to be Tested (print): _____

Campus: _____ **Assignment:** _____

Date of Birth: _____ **Phone Number:** _____

Address: _____

Signature of Person Tested_____

DISTRICT USE ONLY:

Received by (name) _____on (date/time) _____

Place of test administration: _____ on (date/time) _____

Please answer the following questions by circling and entering appropriate information:

Is this the first test (of any kind) the patient has had for COVID-19? No Yes

If NO, what type of test was taken before? (Please circle answer.)
Molecular
Antigen
Antibody
Unknown

If NO, what is the date of the last test? (Year and month only)
_____
(YYYY-MM)

Is the patient symptomatic? No Yes

If YES, date symptoms began: (year, month, day only)
_____
(YYYY-MM-DD)

Please circle the correct answer regarding symptoms that the patient has:

N/A	No	Yes	Fever over 100.4F?
N/A	No	Yes	Feeling feverish?
N/A	No	Yes	Chills?
N/A	No	Yes	Cough?
N/A	No	Yes	Shortness of breath?
N/A	No	Yes	Difficulty breathing?
N/A	No	Yes	Fatigue?
N/A	No	Yes	Muscle or body aches?
N/A	No	Yes	Headache
N/A	No	Yes	New loss of taste?
N/A	No	Yes	New loss of smell?
N/A	No	Yes	Sore Throat?
N/A	No	Yes	Nasal congestion?
N/A	No	Yes	Runny nose?
N/A	No	Yes	Nausea?
N/A	No	Yes	Vomiting?
N/A	No	Yes	Diarrhea?
N/A	No	Yes	Is the patient pregnant?