Cabarrus County Schools
Engaging minds. Shaping futures.

INFORMED CONSENT FOR COVID-19 STAFF TESTING

Employee Name: Last: _____First: _____Middle Initial: _____DOB: _____

Position: _____ School/Location: _____ Principal/Supervisor: _____

Please carefully read the following informed consent:

1. I authorize Cabarrus County Schools to conduct collection and testing for Covid-19 through a nasopharyngeal swab as ordered by an authorized medical provider or public health official. I understand that this testing is voluntary and that I am not required to undergo such testing as a condition of my employment.

2. I authorize my test results to be disclosed to Cabarrus County Schools and to any applicable county, state, or other governmental entity as may be required by law and understand that such disclosure will also be made consistent with applicable law. Results should be emailed to **CCSEMPLOYEEHEALTHEXPOSURE@CABARRUS.K12.NC.US**

3. I acknowledge that a positive test result is an indication that I must abide by Cabarrus County Schools isolation and quarantine policies and all applicable federal, state and/or local guidance on isolation and quarantine to avoid infecting others. **Email results/questions**: **CCSEMPLOYEEHEALTHEXPOSURE@CABARRUS.K12.NC.US**

4. I understand that by signing this document and agreeing to undergo Covid-19 testing that I am not creating a patient relationship with Cabarrus County Schools. I understand that Cabarrus County Schools 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.

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

6. I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident or illness during this activity or event. I release Cabarrus County Schools and its employees from liability for any injury, accident or illness during testing or any expenses incurred due to further treatments needed.

ACCEPTANCE

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.

Signature:_____ Last 4 Digits of SS#_____ Date: _____

DECLINATION

I decline COVID-19 testing at this time. Cabarrus County Schools has reviewed, and I understand, potential risks of not participating in baseline testing and that declining testing may affect my ability to work until I am tested.

Signature:_____ Last 4 Digits of SS# _____ Date: _____

STAFF INFORMATION Below FOR CCS HR AND CLINICAL USE ONLY
Negative Test with Symptoms Requires PCR Test and Alternative Diagnosis to exit quarantine/isolation early.
Positive Test/Close Contact with/without Symptoms: Must complete CCS HR Quarantine/Isolation
EMAIL RESULTS/QUESTIONS: CCSEMPLOYEEHEALTHEXPOSURE@CABARRUS.K12.NC.US

Test Result	Date and Time Read	Signature of Nurse Performing Test

Test CPT -87811
DX - Z20.828 Notes_____
Data entry completed by: _____(initials)