COVID-19 TESTING AND REPORTING CONSENT FOR STUDENTS AND EMPLOYEES

1. I understand that Black Hawk College has partnered with the University of Illinois to provide the SHIELD Illinois PCR COVID-19 testing.
2. I authorize this COVID-19 testing site to conduct collection and testing of my saliva for COVID-19.
3. I authorize my test results to be disclosed to Black Hawk College Contact Tracer/designee and to county, state, or any other governmental entity as may be required by law.
4. I understand that I could receive my test results via a web portal, phone call, text message, email, or mail. I authorize contact through any of these options, including leaving a detailed voicemail with the test results.
5. I acknowledge that a positive test result is an indication that I must immediately self-isolate to avoid infecting others. If I receive a positive test result while on campus, I will immediately leave the premises.
6. I understand the testing site 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.
7. I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.
8. I understand that it is my responsibility to correspond in a timely manner with the BHC Contact Tracer/designee and will follow the College directives issued.
9. I voluntarily agree to testing for COVID-19.
10. I understand that I have the right to revoke this consent at any time by delivering a written revocation to RiskManagement@bhc.edu.
11. I, the undersigned, have been informed about the SHIELD Illinois PCR COVID-19 testing. I have been offered a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and understand that I can ask other questions at any time.

I HAVE READ THIS DOCUMENT AND UNDERSTAND ITS CONTENT. I UNDERSTAND THAT BY SIGNING BELOW, I CONFIRM AGREEMENT OF DISCLOSING MY TEST RESULTS TO BLACK HAWK COLLEGE AND AGREE TO PARTICIPATE IN SAID EVENT WITH SUCH KNOWLEDGE AND UNDERSTANDING. I FURTHER CONFIRM I HAVE VOLUNTARILY SIGNED THIS CONSENT AND AGREED TO WAIVE ANY AND ALL CLAIMS FORFEITED HEREIN. I AGREE THIS DOCUMENT IS NOT ONLY BINDING ON ME BUT WILL ALSO BE BINDING UPON MY PERSONAL REPRESENTATIVES, EXECUTORS, HEIRS AND NEXT OF KIN.

Signature of Participant ______________________________ Date ______________

Printed Name ______________________________ Address ______________________________

Phone ______________________________ Email ______________________________

PARENT or GUARDIAN CONSENT (If participant is under age 18): I am the parent or legal guardian of the participant and I agree that the foregoing agreement shall be binding on me and the minor participant.

Signature of Participant's Parent or Guardian ______________________________ Date ______________

IN CASE OF EMERGENCY

Printed Name ______________________________ Relationship ______________________________

Address ____

Home#: ____________________ Cell#: ____________________ Other#: ____________________

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