UNF UNIVERSITY of NORTH FLORIDA.

Policy Name: COVID PCR and Antigen Testing	
Date Created: 11/17/20	Revised: 7/26/21
Approved by Director: 7/26/21	Approved by CMS: 7/26/21

COVID-19 Rapid Antigen and PCR Test Report Form

Name: ______________________________ **N#:** _______________ **Date:** ___________
(Please PRINT legibly)

Student:☐ Staff/Faculty/Employee:☐

In the last 14 days, have you had close contact with anyone that you know has been diagnosed with COVID-19?

☐ Yes ☐ No Date of Exposure:_________________ Are you fully vaccinated? ☐ Yes ☐ No

Have you had a positive COVID-19 test for active virus in the past 90 days? ☐ Yes ☐ No

Symptoms: (Choose all that apply)

☐ Asymptomatic (No symptoms)

☐ Fever or Chills ☐ Cough ☐ Shortness of Breath ☐ Fatigue ☐ Muscle or Body Aches

☐ Headache ☐ New Loss of Taste/Smell ☐ Sore Throat ☐ Congestion/Runny Nose

☐ Nausea or Vomiting ☐ Diarrhea **Date of Symptom(s) Onset:** _______________

Please carefully read and sign the following Informed Consent:

a. I authorize this COVID-19 testing unit provided by the University of North Florida to conduct collection through a nasopharyngeal/nasal swab or blood draw and to test for COVID-19, and if a PCR COVID-19 is required testing to be provided by the Gravity Diagnostics, LLC Laboratory.
b. I authorize my personal information be entered into the third-party data collection system provided by Orchid ® Copia ®, a vendor selected by testing lab Gravity Diagnostics, LLC, where my specimen will be sent and tested.
c. I authorize my test results and other information to be disclosed to any governmental entity as may be required by law.
d. I acknowledge that a positive test result is an indication that I must isolate in accordance with CDC and UNF guidelines, and wear a mask or face covering as directed in an effort to avoid infecting others.
e. I understand the UNF testing unit is not acting as my medical provider. This testing does not replace treatment by my medical provider, and 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 I become ill or my condition worsens.
f. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
g. I understand testing has limitations, and even with a negative result my symptoms or exposure history may still warrant isolation or quarantine.

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 additional questions at any time.

I voluntarily agree to this testing for COVID-19. Signature of Individual to be Tested (or appointed guardian if under 18):

Sign: ____________________________________ Date:____________________