College of Health Professions
Community Health Center
2500 West North Ave., Baltimore, MD 21216
Suite 131
Phone (410) 951-4188

Consent for COVID-19 Testing

Name: _____ **COPPIN Email:** _____

Complete Home Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Check one: ◯ **Student** ◯ **Staff/Faculty/Administration** ◯ **Contractor**

Phone Number: _____ **D.O.B:** _____ **CSU ID:** _____

Last 4 SSN: _____ **Legal Sex:** _____ **Ethnicity:** _____ **Race:** _____

Ethnicity: **1.** Hispanic or Latino **2.** Not Hispanic or Latino **3**. Unknown **4.** Declined to Answer

Race: 1. American Indian or Alaska Native **2.** Asian **3.** Black or African American
4. Native Hawaiian or Other Pacific Islander **5.** Other **6.** Unknown **7.** White **8.** Declined to Answer

Please read carefully and sign the following Informed Consent:

- I authorize this COVID-19 test station to conduct collection and testing for COVID-19 through a nasal swab (pending available test kits, done either by a sampler or by self, under direct supervision).
- I understand my test results may be disclosed to the University, my supervisor, human resources, and to any agency as may be required for public health purposes.
- I acknowledge that a positive test result is an indication that I must self-isolate for 14 days or as directed by my healthcare provider to avoid infecting others.
- I understand that this testing station is not acting as my medical provider, that 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 will seek medical advice, care and treatment from my medical provider if I have questions or concerns.
- I understand that, as with any medical test, there is a potential for a false positive or false negative COVID-19 test result.

Signature: _____ Date: _____

COVID-19 Screening

- Do you have a fever or above-normal temperature (>100.4°F) Today's Temperature: _____ (checked at testing)	□ Yes	□ No
- Are you experiencing shortness of breath, trouble breathing, dry cough, runny nose, loss of smell or taste, sore throat, chills, unexplained muscle pains headache or diarrhea?	□ Yes	□ No
- Even if you don't currently have any of the above symptoms, have you experienced any of them in the past 14 days?	□ Yes	□ No
- Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	□ Yes	□ No