**INFORMED CONSENT FOR COVID-19 TESTING**

**Employee Name:** Last:  First:  Middle Initial:

**VT Employee ID Number:**

**Please carefully read the following informed consent:**

1. I authorize Virginia Polytechnic Institute and State University (“Virginia Tech”) to conduct ongoing collection and testing for Covid-19 through a nasopharyngeal swab. 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 Virginia Tech and to any applicable county, state, or other governmental entity as may be required by law and understand that such disclosure will be made consistent with applicable law. I understand that my test results may be shared within Virginia Tech, including my supervisor, on a need to know basis.
3. I acknowledge that a positive test result is an indication that I must abide by Virginia Tech’s isolation and quarantine policies and all applicable federal, state and/or local guidance on isolation and quarantine to avoid infecting others.
4. I understand that by signing this document and agreeing to undergo Covid-19 testing that I am not creating a patient relationship with Virginia Tech. I understand that Virginia Tech 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 understand that I will be notified electronically of my test results and that if I wish to be notified via phone I will provide the best contact number here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**ACCEPTANCE**

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for Covid-19.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**

**If under 18 years of age:**

**Signature of parent or guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**