Consent for COVID-19 Testing

Note: Your consent to the use of test results described below facilitates critical public health efforts. Failure to provide consent may result in your ineligibility to participate in on-campus activities.

(Circle One) Student  Faculty  Staff  Other______________________________

Name:__________________________________________________________________________

University of Utah ID#:_________________________  Phone#:__________________________

Please carefully read and sign the following Informed Consent:

a. I authorize the University of Utah and its agents and employees to test me for COVID-19. The purpose of this testing is to enhance the safety and well-being of our campus community. The testing and its results will be used for campus-related contact tracing, to track COVID-19 prevalence within the campus community, and to adjust campus protocols and programming as necessary.

b. The data will be collected by the University of Utah, with samples tested at ARUP Laboratories. A backup lab may be used when processing times are not otherwise sufficient to meet student public health needs. Data and test results may be shared, as required by law, with the Utah Department of Health. In addition, the data and test results may be shared with University of Utah health care providers, University of Utah administrators, and other regulatory or oversight bodies as may be legally required for the purposes described above. Your testing data will not be shared outside of the above described purposes.

c. I acknowledge that a positive test result is an indication that I must self-isolate as directed in an effort to avoid infecting others.

d. I understand that the testing unit is not acting as my medical provider and that this testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action regarding 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.

e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, consent to testing and authorize my information and test results to be shared as described above. 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.

____________________________________  ____________________________  ___________________________________
Date  First Name  Last Name

Signature of Staff, Student or Student’s Appointed Guardian (if under 18 years of age)