COVID-19 Antigen Rapid Test Result

Date & Time of Test: _____

POC Provider Name: _____ Patient Name: _____

POC Provider Signature: _____ Patient Signature: _____

Test Lot#: _____ Valid Until: (72 hrs, date/time) _____

Test Expiration Date: _____ Location of Test: _____

Test Result: _____ (Negative, Positive)

I, _____, agree to hold harmless **Company Name** for the Covid-19 Antigen Rapid Test Device Nasal Swab procedure and results. I acknowledge that the test results may provide a negative result if the level of the antigen is below the detection limit of the test. I understand that a positive reading will not differentiate between SARS-CoV and SARS-CoV-2. I authorize **Company Name** to administer the test as my Point of Care person. I will hold harmless **Company Name**. for any False – Positive, or False – Negative results from the Covid-19 Antigen Rapid Test.

_____

(Patient Signature)