**Consent form for Visitors to (Name of care home) for a COVID-19 Lateral Flow Test.**

|  |  |
| --- | --- |
| Unique Organisation Number |  |
| Care Home name and address (including postcode) |  |

**The person taking the test:**

|  |  |
| --- | --- |
| First name: | Surname: |
| Sex: | DOB: |
| Address:(Including postcode) | Mobile:Landline: |
| Date of test: |
| Barcode Ref:  |
| GP Details contact details: | Emergency contact name and contact details: |

**We ask you to confirm you understand and agree to how the testing is done. If you do not understand or agree to any of the following please speak to the person in charge for further explanation.**

|  |  |
| --- | --- |
|  | I agree to taking the Lateral Flow Test |
|  | I understand that my participation is voluntary |
|  | I understand how my personal information and test results will be used |
|  | I confirm that should I receive a positive test result; a PCR test will be required and I will immediately self-isolate according to government guidelines,  |
|  | If I get a positive test result, I agree for my contact details and test result to be shared with my local Test and Public Health Team for follow up PCR test and contact tracing.  |
|  | I understand my data will be stored processed and destroyed safely under GDPR and Data Protection Act 2018. |
| Signature of test administrator: | Date: |
| Signature of person being tested: | Date: |

**If the service has clinical waste disposal, the LFD test device and equipment will be disposed of onsite.**

**If the service does not have clinical waste disposal:**

I can confirm that I am taking the test device and equipment away with me in a sealed bag provided and disposing of it.

Name: Signature: