ATCHISON COUNTY HEALTH DEPARTMENT
421 MAIN
TARKIO, MO 64491
660-736-4121

Public Health
Prevent. Promote. Protect.

INFORMED CONSENT FORM
COVID-19 Serology Test Survey

The purpose of Serology Test and survey is to explore the number of individuals who may have COVID-19 antibodies in Atchison County, Missouri and obtain a more accurate assessment of COVID-19 in our community. You are invited to participate in this survey because you are a resident of Atchison County, Missouri; you are 18 years old or have the consent of an adult.

Personal information obtained during this survey will be kept strictly confidential. Only the Atchison County Health Department will have access to individual collected information. It may be possible that agencies helping with testing may see information as it is collected; however, individual survey data will be maintained at the Atchison County Health Department and not shared with any entity or agency. When completed, survey results will be presented only in a summary format – no individuals will be identified. Summary results may include such items as,

- Number of individuals who participated in the survey
- Number of individuals who tested positive for COVID-19 antibodies
- General statements regarding career groups i.e., "Three of 74 individuals who report a career in education tested positive for COVID-19 antibodies."
- General statements regarding gender, race, ethnicity, and age of those individuals who participated
- General statements regarding gender, race, ethnicity, and age of those who tested positive for COVID-19 antibodies, i.e., "Six of 112 people age 20-29 tested positive for COVID-19 antibodies."
- General identification of symptoms experienced by residents during times of illness
- And others.

By agreeing to participate in this survey, all costs associated with this test will be covered. If you choose not to participate in this survey, all costs will be billed directly to you.

I hereby agree to participate in the Serology Testing, that I will release my information from this test to the Atchison County Health Department and voluntarily agree to participate in the survey. I have read and understand the information presented including the educational handout. **I further understand, if this test yields a positive result of antibodies, I agree to provide further data as requested.**

I agree to indemnify and hold harmless Atchison County Health Department and their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns against any and all claims, suits, or actions of any kind whatsoever for liability, damages, compensation, or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf.

Name of Participant - Please Print _____

_____ _____
Signature of Participant or Guardian Date

_____ _____
Signature of Witness Date

Community Hospital
Fairfax

Consent for Treatment

I, the undersigned, consent to the drawing of blood for purposes of the COVID-19 Serology Test Survey being conducted by the Atchison County Health Department.

I agree to indemnify and hold harmless Community Hospital Association and its affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns against any and all claims, suits, actions or judgments of any kind whatsoever for liability, damages, compensation, or otherwise brought by me or anyone on my behalf, including attorney's fees and related costs, if any dispute arises pursuant to any claims made by me or by anyone else on my behalf.

I acknowledge and agree that Community Hospital Association may use and disclose my personal information to treat me, run its organization, and bill for my services, as outlined in its HIPAA, Notice of Privacy Practices. I further acknowledge and agree that Community Hospital Association may release my information and test results to the Atchison County Health Department for purposes of the COVID-19 Serology Test Survey being conducted by the Atchison County Health Department.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE, IS OVER 18 YEARS OF AGE OR HAS LEGAL AUTHORITY TO EXECUTE A CONTRACT, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date of Signing_____Time _____

Patient_____

Patient's Agent or Representative _____

Relationship to Patient_____

Witness_____

ATCHISON COUNTY HEALTH DEPARTMENT ---- DATA COLLECTION FORM FOR ANTIBODY TESTING

Public Health
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_____

FIRST NAME MIDDLE NAME OR INITIAL LAST NAME

_____

ADDRESS CITY STATE ZIP CODE

_____

COUNTY PHONE # DATE OF BIRTH

SEX ( ) Male ( ) Female ( ) Prefer not to answer

ETHNICITY ( ) Hispanic/Latino ( ) Non-Hispanic/Latino ( ) Prefer not to answer

RACE ( ) American Indian/Alaskan Native ( ) Black ( ) Asian ( ) White
( ) Native Hawaiian/Other Pacific Islander ( ) Unknown ( ) Other_____

Employment Category
( ) Healthcare ( ) Government ( ) Self employed
( ) First Responder ( ) Retail ( ) None
( ) Education ( ) Construction ( ) Other: _____

Health care worker Information:
( ) Physician ( ) Respiratory Therapist
( ) Nurse ( ) Environmental services
( ) Other:_____

Job Setting:
( ) Hospital ( ) Rehabilitation Facility
( ) Long term care ( ) Nursing home/assist living
( ) Other:_____

Have you ever been tested for COVID-19? Y N DK

Have you tested positive for COVID-19? Y N DK

Have you ever been in contact with another person who tested positive for COVID-19? Y N DK

Did you experience COVID-19 like illness in the past 3- 6 months? Y N
If NO, you may stop here.
If YES, PLEASE CONTINUE:
Estimated Dates of Illness (Month/Year and Dates (if able to remember))_____

Were you hospitalized during this time of illness? Y N DK
If yes: Did you develop pneumonia: Y N DK
Did you have acute respiratory distress syndrome? Y N DK
Did you have an abnormal chest x-ray Y N DK
Did you have another diagnosis/etiology for your illness Y N DK
Did you have an abnormal EKG? Y N DK
Did you receive mechanical ventilation? Y N DK
If yes, how many days? _____
Did you receive ECMO? Y N DK

Which would best describe where you were staying at the time of your illness?
( ) House/single family home ( ) Apartment ( ) Camper/RV
( ) Group home ( ) Homeless shelter ( ) Hotel/motel
( ) Long term care facility ( ) Nursing home/assisted living facility
( ) Acute care inpatient facility ( ) Rehabilitation facility
( ) Correctional facility ( ) Other:_____

ATCHISON COUNTY HEALTH DEPARTMENT ---- DATA COLLECTION FORM FOR ANTIBODY TESTING

Did you experience the following symptoms during your time of illness?	**Yes**	**No**	**Don't Know**
Fever greater than 100.4°F?			
Felt feverish?			
Had chills?			
Experienced headaches?			
Soreness?			
Sore throat?			
Cough or worsening cough?			
Nausea or vomiting?			
Runny nose?			
Shortness of breath?			
Abdominal pain?			
Diarrhea?			
Loss of sense of taste or smell?			

EXPOSURE INFORMATION:

Two weeks before your illness, did you have any of the following exposures:

( ) Have domestic travel (outside state of normal residence). Specify state:_____

( ) International travel. Specify country:_____

( ) Cruise ship or vessel travel as passenger or crew member. Specify name of ship:_____

( ) Workplace

Is the workplace a critical infrastructure? Y N If yes, Specify:_____

( ) Airport/airplane

( ) Adult congregate living facility (nursing, assisted living, long term care facility)

( ) School/university

( ) Childcare center

( ) Correctional facility

( ) Community event/mass gathering

( ) Other:_____

( ) Unknown

PRE-EXISTING MEDICAL CONDITIONS

Chronic Lung Disease (asthma/emphysema/COPD)	Y	N	DK
Diabetes	Y	N	DK
Heart Disease	Y	N	DK
Chronic Kidney Disease	Y	N	DK
Liver Disease	Y	N	DK
Immunocompromised condition	Y	N	DK
Neurologic/neurodevelopmental/intellectual disability	Y	N	DK
Other chronic diseases	Y	N	DK
If female, currently pregnant	Y	N	DK
Current Smoker	Y	N	DK
Former Smoker	Y	N	DK

Specify other chronic diseases:_____