



**UAFS ID#** @\_\_\_\_\_

**Medical Consent for Administration of COVID-19 Test**

I, the undersigned, authorize and consent to the rendering of a COVID-19 test by medical professionals staffing the Powell Student Health Clinic.

**Waiver of Liability**

I, the undersigned, hereby release and hold harmless University of Arkansas at Fort Smith and its contracted vendor, HealthSmart Primary Care Clinic, its employees, agents, and representatives, of and from all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to the administration of COVID-19 testing provided by the medical technicians of HealthSmart Primary Care Clinic.

Acceptance and Signature

Date \_\_\_\_\_

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