Office use only

Date of testing _____

ANTIGEN- + ☐

– ☐

NEGATIVE ANTIGEN ☐

Push to clear all fields

Please print clearly

Name: _____ _____
Last ***First***

Date of Birth: _____

Address: _____ _____ _____
Street ***Town*** ***Zip Code***

Phone number: _____ _____
Primary ***Secondary***

What is your ethnicity/race: *Please circle/select*

☐ **White** ☐ **Hispanic** ☐ **Asian** ☐ **Black** ☐ **American Indian** ☐ **Native Hawaiian** ☐ **Other**

1. **Have you been sick in the past 16 days?** YES or NO
   If yes, please list your symptoms _____
   _____

2. **Have you tested positive for COVID-19?** YES or NO

   Date of COVID-19 test _____

   If yes, please list your symptoms _____

   _____

   Date symptoms began _____ **Date ended** _____

3. **Have any of your close contacts or family members tested positive for COVID-19 or been told they have had COVID 19 in the past?**

   YES or NO