YOU MUST RETURN THIS SHEET TO RECEIVE YOUR TEST RESULTS
(PLEASE PRINT CLEARLY!)

Testing Date: ____________________

First Name: ______________________ Middle Initial: _____ Last Name: ______________________

Date of Birth: ____________________ Age: _________

Street Address: ______________________________________________________________

City: ______________________________ State: ___________ Zip Code: __________________

Telephone for Results: ______________________ Email Address: ______________________

Have you had contact with a confirmed COVID-19 case? (Circle): YES NO

Confirmed COVID-19 Case: ______________________________ Date of Contact: ___________________

Are you experiencing any of these symptoms?

☐ Fever/ (Temp. greater than 100.4) ☐ Headache

☐ Hot Flashes / Chills ☐ Abdominal Pain

☐ Cough ☐ Nausea/vomiting

☐ Shortness of breath ☐ Diarrhea

☐ Fatigue ☐ Sore throat

☐ Muscle aches/Body aches ☐ Runny nose/ Congestion

☐ Conjunctivitis – pink eye ☐ Change or lack of taste / smell

YOU MUST RETURN THIS SHEET TO RECEIVE YOUR TEST RESULTS
(PLEASE PRINT CLEARLY!)

Testing Date: ____________________

First Name: ______________________ Middle Initial: _____ Last Name: ______________________

Date of Birth: ____________________ Age: _________

Street Address: ______________________________________________________________

City: ______________________________ State: ___________ Zip Code: __________________

Telephone for Results: ______________________ Email Address: ______________________

Have you had contact with a confirmed COVID-19 case? (Circle): YES NO

Confirmed COVID-19 Case: ______________________________ Date of Contact: ___________________

Are you experiencing any of these symptoms?

☐ Fever/ (Temp. greater than 100.4) ☐ Headache

☐ Hot Flashes / Chills ☐ Abdominal Pain

☐ Cough ☐ Nausea/vomiting

☐ Shortness of breath ☐ Diarrhea

☐ Fatigue ☐ Sore throat

☐ Muscle aches/Body aches ☐ Runny nose/ Congestion

☐ Conjunctivitis – pink eye ☐ Change or lack of taste / smell