a. I authorize Kanab United Drug to conduct collection and testing for COVID-19 as ordered by an authorized medical provider or health official.

b. I understand, as required by law, my test results will be disclosed to the county, state, or to other government entities.

c. I understand Kanab Drug is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

d. I understand that, as with any medical test there is a potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time and have been given instructions on how to obtain a copy of this informed consent. I voluntarily agree to this testing for COVID-19.
Patient Questionnaire

Do you have any of the following medical conditions?

____Hemoglobin Disorders    ____Severe Heart Condition    ____Obesity
____Cancer Treatment   ____Kidney Disease that requires dialysis  ____HIV
____Moderate/Severe Asthma  ____Corticosteroid Treatment   ____Diabetes
____Bone Marrow/Organ Transplant   ____Immune System Dysfunction

Drug Allergies: _____________________________________________________________

Is this the 1st time you have been tested for COVID-19? ________________________________

Are you employed in a healthcare setting? ____________ If so, what is your occupation? ________________________________

Are you experiencing any of the following symptoms?

____Chills     ____Shortness of breath    ____Nasal discharge
____Vomiting   ____Sore throat     ____Nausea
____Nasal congestion   ____Cough     ____Muscle pain
____Loss of sense of taste   ____Loss of sense of smell   ____Headache
____Fever over 100.4 F   ____Feeling feverish     ____Fatigue
____Difficulty breathing   ____Diarrhea

What date did you start experiencing symptoms? __________________________________________

Do you currently live in a congregate setting? If so what type of setting? ________________________________

Method of Payment:

Card number_______________________________________ Expiration date:________________ CVV Code__________

FOR OFFICE USE ONLY

____POSITIVE      ____NEGATIVE

COMPLETED BY__________________________________________