PATIENT COVID SCREENING/CONSENT FORM
DIAGNOSTIC TESTING AND HEALTH SCREENING
KANAB UNITED DRUG
(435) 644-2418

Patient Name (print)_____ **Date**_____

Date of Birth____ /____/_____ **Phone** _____**Email**_____

Address_____**City**_____**State**_____**Zip**_____

Gender: M_____F_____ **Pregnancy Status:** Yes_____ No_____

Race:		.	**Ethnicity:**
____White	____Black/African American	.	____Hispanic or Latino
____Alsakan Native	___Native Hawaiian	.	____Not Hispanic or Latino
____American Indian	____Pacific Islander	.	____Other
____Unknown		.	____Unknown

---

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 Name (print)_____

Patient Signature _____

Representative Name (print)_____

Representative Signature_____

Signature of Witness if verbal consent obtained_____

Primary Care Doctor_____

CONTINUES ON BACK ---->

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_____