Sid's Pharmacy
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Pullman, WA 99163
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COVID-19 Testing Consent Form

Name: _____ **Date of Birth:**_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Sex:** ☐ Male ☐ Female

Make & Model of vehicle you will be arriving in: _____

Were you exposed to COVID-19: ☐ No ☐ Yes If yes, did you experience direct exposure to a COVID-19 positive person (*e.g. someone who lives with you*)? ☐ No ☐ Yes
Approximately how many days ago were you exposed to COVID-19? ☐
Is this test travel related? ☐ No ☐ Yes

What symptoms are you experiencing now? *Please select all that apply*.

- ☐ Fever or chills
- ☐ Cough
- ☐ Fatigue
- ☐ Muscle or body aches (i.e., myalgia)
- ☐ Headache
- ☐ Congestion or runny nose
- ☐ Sore throat/Hoarseness
- ☐ New loss of taste or smell
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Shortness of breath or difficulty breathing

Mild Moderate Severe

☐ **No symptoms**

For how many days have you been experiencing symptoms? _____

Patient signature: _____ **Date:**_____

Symptoms of Coronavirus accessed from CDC website on September 16, 2020, available at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html