

**Sid's Pharmacy**

**825 SE Bishop Blvd, Ste 301**

**Pullman, WA 99163**

**Phone (509)332-4608 Fax (509)332-3341**

**Covid Testing Consent Form**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Sex:** Male  Female  Non-Binary  Unspecified/Indeterminate

**Email:** \_\_\_\_\_

**Make and Model of vehicle you will be arriving in:** \_\_\_\_\_

**Were you exposed to Covid-19:** No  Yes  If yes, approximate date of exposure: \_\_\_\_\_

**Is this test travel related?** No  Yes  **Are you vaccinated against Covid-19?** 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  Diarrhea

New loss of Taste or Smell  Congestion/runny nose  Sore throat/Hoarseness  Nausea or Vomiting

Shortness of Breath: Mild  Moderate  Severe  No Symptoms at this time

**Insurance Information**

**Name of Insured:** \_\_\_\_\_ **Insured Member ID:** \_\_\_\_\_

**Primary Cardholder:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Primary Cardholder ID:** \_\_\_\_\_

**Patient/Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*Please note: Sid's Pharmacy reserves the right to refuse testing without valid insurance or payment at the time of service.