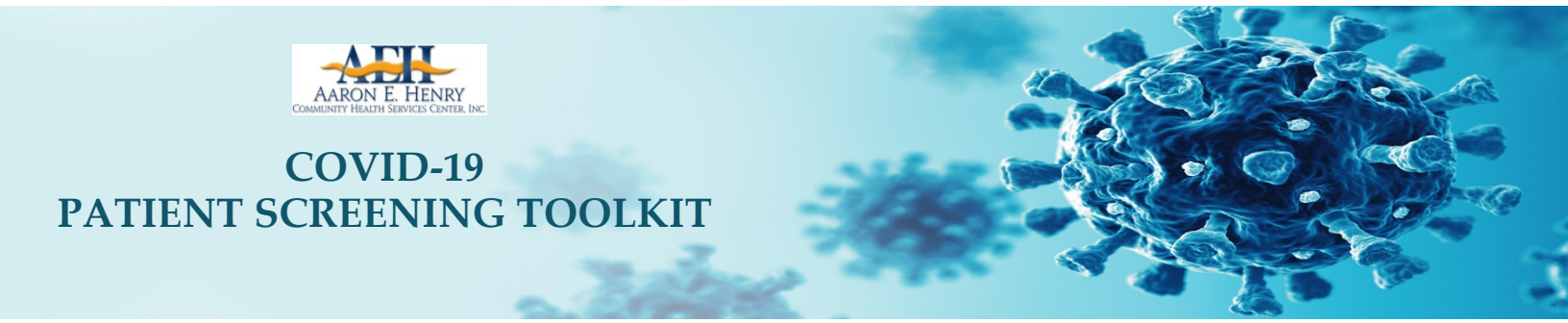

COVID-19
PATIENT SCREENING TOOLKIT

Date/Location:					
Coronavirus Symptoms					
Do you have a cough?	**yes**	**no**	Are you experiencing fatigue?	**yes**	**no**
Do you have a fever?	**yes**	**no**	Do you have Diarrhea?	**yes**	**no**
Are you having trouble breathing?	**yes**	**no**	Do you have chills?	**yes**	**No**
Are you experiencing loss of smell or taste?	**yes**	**no**	Do you have a sore throat?	**yes**	**no**

Please bring your insurance card and ID when you come for testing.

YOU WILL NOT BE CHARGED a co-pay. We will bill your insurance company.

Do you have insurance?		Yes	No
Insurance Carrier	Policy #		

Demographic Information	
Patient Name:	Age:
Date of Birth:	Social Security #:
Address:	
City/St/Zip:	Phone #:
Ethnicity:	Race:
Gender:	Gender Identification:
Emergency Contact Information: Name:	Phone #: Relationship:

Authorization For Use & Disclosure

I _____ (print name) attest that I am legal guardian of the minor child named above and further give Aaron E. Henry Community Health Services Center permission to test the minor child named above for COVID-19.

Signature_____(parent/guardian)

Patient Signature	*Date*