Covid-19 Rapid Antigen Test

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Patient Information:

First Name: _______________ Last Name: ____________________ Date of Birth: ____/_____/_______
Race: _________ Gender: __________
Street Address: ____________________ City: ____________ State: _____ Zip Code: ________________
Phone Number: _________________________ Email: ___________________________

Screening Information:

Date of Screening: ___/___/______

Do you have any symptoms? (Check all that apply)

☐ Fever
☐ Chills
☐ Cold Sweats
☐ Muscle Aches
☐ Headache
☐ Sore Throat
☐ Loss of sense of taste
☐ Loss of sense of smell
☐ Cough
☐ Difficulty breathing
☐ Vomiting
☐ Diarrhea
☐ Fatigue
☐ Congestion

When did your symptoms begin? ____
Have you had direct contact with someone with confirmed Covid-19? ☐ Yes ☐ No

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For Pharmacy Documentation Only:

Date of test: ____
Test administered: _______________________________________
Pharmacist administering test: ____________________________

Test Results:

☐ Positive ☐ Negative ☐ Inconclusive