Kankakee School Based Health Clinic COVID Testing Registration

Patient ID#_____

Please check one: □ Student □ Staff **School/Work Place**: _____

Patient Name: _____ **Date of Birth**: _____ **Sex**: □ Male □ Female

Race: _____ **Ethnicity**: □ Hispanic □ Non-Hispanic

- Patient Home Address: _____

  City: _____State: _____ Zip Code: _____

- Home Phone: _____Cell: _____

Do you have Medical Coverage? **Yes** / **No** Please check one: □ Medicaid □ Private Insurance

Do you have COVID symptoms? **Yes** / **No**

If **YES** please list symptoms:

_____

_____

Date when symptoms started: _____/_____/_____

Have you been in contact with a **POSITIVE COVID** case within the last 14 days? **Yes** / **No**

For **WOMEN ONLY**: Are you currently pregnant? **Yes** / **No**

1. Do you verbally and voluntarily give consent to the rending of such care, and/or diagnostic testing by authorized members of the Kankakee School District #111 Health Clinic Staff and their designees for COVID-19 Ag Abbott BiaxNOW testing for you or your minor? **YES** / **NO**
2. Do you consent to results being released to the Illinois Department of Public Health? **YES** / **NO**

** If you do **NOT** consent to results being released we **CANNOT** do your testing today. **

Patient Signature: _____ Date: ____/____/____

(Parent/Guardian Name if patient is a child)

Verbal Consent (over the phone)

Verbal Consent Given By: _____ Self / Parent / Guardian Date: ____/____/____

Witness by Staff Signature: _____ Date: ____/____/____

2nd Verbal Witness by Staff Signature: _____ Date: ____/____/____

Revised 09/07/2022