SARS-COV-2 Antigen Rapid Screening Test

Name_______________________________________**DOB:** ____________________**Age:**_______

Phone: _______________________ **Email:**____

Address:_________________________________ **Employer (if applicable):**________________________________

City:______________________________

State:______ **Zip:**_________________

Sex:	**Ethnicity:**
Male Female	☐ American Indian or Native Alaskan
Current Smoker:	☐ Asian
Yes No	☐ Black or African American
Pregnant:	☐ Hawaiian or Pacific Islander
Yes No	☐ White
	☐ Not Listed

1. What is the reason for requesting the test?
2. Are you experiencing any symptoms?
3. Have you ever tested positive for SARS-COV-2?

   ☐ **YES** ☐ **NO**

   If Yes, Date:_________________
4. Have you traveled in the past 4 weeks? ☐ **YES** ☐ **NO**

Rapid Covid-19 Antigen Test Results

I,___________________________ (Name of Person Receiving Test or Legal Guardian) authorize Berkley Urgent Care to conduct collection and testing for COVID-19 through a nasopharyngeal swab. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I understand that I am not creating a patient-provider relationship with Berkley Urgent Care by participating in testing. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from a medical provider if I have any symptoms of COVID-19, questions or concerns. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.