Consent and Registration Form for Rapid COVID-19 Antigen Test

Testing Facility: ______________________________

Address: ______________________________

Phone: ______________________ Organization: ______________________

Testing Date: ____________

Personal Information

First Name: ____________ Last Name: ____________ Middle: ____________

Phone Number: ( ) - ______ - ______ Email Address: ______________

DOB: (mm/dd/yyyy) ____ /____ / ______ Biological Sex: * Male * Female * Prefer not to answer

Street Address: ______________________________

City/State/Zip: ______________________________

Race: Please check the box next to the one that best describes your race.

- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Asian
- ☐ White/Caucasian
- ☐ Hawaiian/ Pacific Islander
- ☐ Other
- ☐ Unknown

Hispanic or Latino: Please check the box next to one of the following that best describes your ethnicity.

- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic
- ☐ Unknown or Decline to specify

Arab or Middle Eastern: Please check the box next to one of the following that best describes your ethnicity.

- ☐ Arab or Middle Eastern
- ☐ Not Arab or Middle Eastern
- ☐ Unknown or Decline to specify

Do you have symptoms related to COVID-19? ☐ Yes ☐ No ☐ Unknown

If yes, what is the date the symptoms started? ______________________

**Have your insurance information ready in case antigen test is negative and saliva PCR test is indicated. For those without insurance, no-cost test state-run test sites are available.*