

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.*