Bear River Health Department
Rapid COVID-19 Testing Information Sheet

Patient Information Section

Patient First Name _____ *Middle* _____ *Last* _____

Patient Street Address _____ *Apt #* _____ *City* _____ *State* _____ *Zip* _____

( ) - _____ *Phone Number*

_____ *email address*

_____ *Date of Birth (MM/DD/YYYY)*

Patient Demographics Section

Birth Gender: ☐Female ☐Male ☐Unknown

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Unknown

Race: ☐Alaskan Native ☐American Indian ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐ White ☐Unknown

Privacy Notice, Acknowledgments and Consents

HIPAA/Privacy:
I acknowledge receipt of a copy of the Bear River Health Department (BRHD) Notice of Privacy Practices for Protected Health Information (Notice) which I have or will carefully review online at brhd.org, and acknowledge my rights for a more complete description and understanding of potential uses, disclosures of and/or requests for such Protected Health Information by BRHD.

I acknowledge that BRHD reserves for itself the right to change the terms of its Notice at any time, and that if BRHD does change the terms of its Notice, I acknowledge the right to obtain a copy of the current revised Notice at any BRHD office or online at brhd.org.

X______________________________ ________________
Signature of Client (or Parent/Guardian/Representative) Date

Consent for Services:
I authorize and consent to the rapid COVID-19 tesing procedure I or ther person for whom I am consenting for are receiving today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the testing procedure being given to me or the person named for whom I am authorized to make a request for the testing services.

I understand that my test results will be shared with the appropriate school district officials for official COVID-19 quarantine assessment purposes only. I also affirm that me or or the person named for whom I am authorized to make a request for the testing services are currently not, nor have been experiencing COVID-19 symptoms since the day I or they started school quarantine period.

X______________________________ ________________
Signature of Client (or Parent/Guardian/Representative) Date

For Testing Staff Use Only:

Performing Lab: ☐Cache County School District ☐Logan City School District ☐Box Elder County School District ☐Rich County ☐BRHD Site ☐ InTech Other ________________

Organism: *Novel Coronavirus* **Test Type:** *Rapid Antigen*

Test Results: ☐Equivocal/Borderline/Indeterminate/Inconclusive ☐Negative/Non-reactive ☐Positive/Reactive

Test Status: *Final* **Specimen Collection:** *Nasal*

Collection Date: ________ *(MM/DD/YYYY)* **Lab Test Date:** ________ *(MM/DD/YYYY)*

Name of School Attending: ________________