Help us find you:

Best number to call you while in car: _____ **Color and make of car:** _____

COVID-19 Screening Form (Fill out completely)

Name: _____Date: _____

SSN or Driver's License #:_____ **Phone number to contact/ text**: _____

E-Mail: **(*required for portal access to receive confirmation results)** _____

Address:_____City_____State:_____Zip:_____

Insurance:_____ ***(please have card and ID for the parking lot staff to collect)***

Birth Date: _____ School/Employer_____

Use email link to setup portal while waiting to receive confirmation results. The school/ employer will need to contact us to receive results only list if you would like them to receive your results

Recent: Height: _____ Weight: _____ (staff to complete)Temp:_____

Ethnicity: Hispanic/Latino Non Hispanic/Latino **Race:** White Black Other_____

_____ Yes _____ No Have you had contact with a person with a confirmed/ Suspected case of COVID-19?

_____ Yes _____ No Have you had a fever within the last 14 days?

_____ Yes _____ No Have you had a forceful dry cough or productive cough within the last 14 days?

_____ Yes _____ No Have you had difficulty breathing or shortness of breath within the last 14 days?

_____ Yes _____ No Have you had chills or repeated shaking with chill within the last 14 days?

_____ Yes _____ No Have you had new unexplained muscle pain within the last 14 days?

_____ Yes _____ No Have you had new or atypical headache for you within the last 14 days?

_____ Yes _____ No Have you had nausea, vomiting or diarrhea within the last 14 days?

_____ Yes _____ No Have you had a sore throat within the last 14 days?

_____ Yes _____ No Have you received COVID vaccinations ____1dose ____2doses?

_____ Yes _____ No Have you had a recent sudden loss of taste or smell?

_____ Yes _____ No Are you pregnant?

_____ Yes _____ No Are you a health care worker?

Office Use
Rapid:
Flu:
Sendout:

Circle or Mark Applicable

Language Preference: English Spanish Other:_____

Who lives at in your home (relation)? Spouse Sibling Parent(s) Children Partner Roommate Other

Medications_____

Please list any Medical Problems: _____

_____

Are you allergic to any medications: ___No ____ Yes:_____

Patient Signature:_____

Signature is consent for release of COVID test results to school/ employer as above, to receive notifications from HAPPI including portal notification of results and general consent for treatment. Please ask for a full consent form for any clarification, including your HIPAA rights