Miami County Public Health
Prevent. Promote. Protect.

COVID-19 Testing Administration Record, Screening, and Patient Consent
Miami County Health Department
CLIA # 17D0665476
1201 Lakemary Drive Paola, KS 66071
Phone: 913-294-2431
Fax: 913-294-9506

Name: _____ **DOB:** _____ **Gender:** ☐ **M** ☐ **F**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **E-Mail:** _____

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Race:** _____

Please select any symptoms of COVID-19 that you are experiencing: **_____ Screening purposes only**

_____ Fever _____ Cough _____ Fatigue _____ Muscle or body aches _____ Headache _____Sore throat

_____ Chills _____ Shortness of breath / difficulty breathing _____ Loss of taste or smell _____Congestion

_____ Runny nose _____ Nausea or vomiting _____ Diarrhea

Date of Symptom Onset, if applicable: _____

Have you been fully vaccinated (>2 weeks since last dose)? ☐ **YES** ☐ **NO**

If yes, which vaccine? ☐ **MODERNA** ☐ **PFIZER** ☐ **JOHNSON & JOHNSON**

Please read the following statements and sign below on the signature line:

I authorize Miami County Health Department to conduct collection and testing for COVID-19 through a nasal swab as ordered by an authorized medical provider or public health official. 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 acknowledge that a positive test result is an indication that I must self-isolate and follow all guidelines and instructions provided by Miami County Health Department. I understand that Miami County Health Department is not acting as my medical provider, this testing does not replace treatment by my medical provider, and 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 my medical provider if I have questions or concerns, or if my condition worsens. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I, the undersigned, have been informed about the test purpose, procedures, and possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

_____ _____

Signature of person receiving test or authorized representative ***Date***

For Facility Use Only: **Test Date and Time:** _____

Antigen	**Nasal mid-turbinate**	**Administered by:**	**Detected**	
PCR	**Nasopharyngeal**		**Not detected**	