Upon Arrival for Your COVID-19 Rapid Test, Please Fill Out This Screening Form and Submit It *Before* Your Test is Taken.

Call **(908) 452-5612** when you have finished the screening and are waiting in the car, ready for your COVID-19 Test.

COVID-19 Screening

Please complete this form before getting a COVID-19 test.

Age 3-15: A parent or legal guardian needs to fill out this form and accompany the patient to visit.
Age 16-17: A parent or legal guardian needs to fill out this form.

All fields are required unless marked as optional.

Patient Name *

First Last

Relationship to Patient *

- I am the patient
- I am the Parent of the Patient
- I am the Legal Guardian of the Patient

Parent/ Guardian Name

First Last

Patient date of birth (mm/dd/yyyy) *

Patient Age *

Patient Sex *

- Male
- Female
- Other

Patient Race *

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White or Caucasian
- Other

Patient Ethnicity *

- Hispanic or Latino
- Not Hispanic or Latino
- Decline to Answer

Address *

Apartment, Suite, or Floor (Optional)

City *

State *

Zip Code *

County of Residency (Eg. Sussex, Morris, Warren, etc.) *

Phone *

Email *

Have you experienced any of these symptoms? (Select any that apply) *

- [ ] Chills
- [ ] Congestion or Runny Nose
- [ ] Cough
- [ ] Diarrhea
- [ ] Fatigue
- [ ] Fever
- [ ] Headache
- [ ] Muscle or Body Aches
- [ ] Nausea or Vomiting
- [ ] New Loss of Taste or Smell
- [ ] Shortness of Breath or Difficulty Breathing
- [ ] Sore Throat
- [ ] NO SYMPTOMS PRESENT

Approximately what date did your symptoms begin? (If no symptoms present, write "NOT APPLICABLE") *

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Do you have any of the following medical conditions? (Select any that apply) *

- [ ] Asthma or chronic lung disease
- [ ] Cirrhosis of the liver
- [ ] Conditions that result in a weakened immune system, including cancer treatment
- [ ] Diabetes
- [ ] Diseases or conditions that make it harder to cough
- [ ] Extreme obesity
- [ ] Hypertension or high blood pressure
- [ ] Kidney failure or end stage renal disease
- [ ] Serious heart condition, such as congestive heart failure
- [ ] I don't have any of these medical conditions

In the past 14 days, have you had known or suspected exposure to the SARS-CoV-2 virus or a COVID-19 patient? (e.g. been exposed to someone with COVID-19 or been in a large public gathering where exposure is suspected) *

- ○ Yes
- ○ No

Is this your first time taking the COVID-19 test? *

- ○ Yes
- ○ No

Have you previously tested positive for COVID-19? *

- ○ Yes
- ○ No

How Did You Hear About Us? *

- ○ Facebook
- ○ Friend Referral
- ○ Google search
- ○ Google Reviews
- ○ Referral
- ○ Sign
- ○ Yelp
- ○ Word of Mouth
- ○ Other

Time and date of your COVID appointment *

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I will bring my valid ID or driver's license and form of payment at the time of my appointment. I am aware that I must pay $100 at the time of my appointment. I understand that I must perform my own nasal swab or bring someone to do it for me. If I have to cancel my appointment, I will call (908) 452-5612 at least 24 hours in advance. *

- [ ] Yes

I acknowledge that I have answered these questions truthfully to the best of my knowledge. *

- [ ] Yes