COVID-19 Testing Questionnaire - CHILD

Name (Last, First): _____

DOB:_____ **Date**:_____ **Phone**: _____

Address: _____

City_____ **State**_____ **Zip**_____

I understand that if my insurance does not cover the cost of the COVID19 test, that I am responsible for any balance. If I am a WSD staff member, I understand that it is my responsibility to forward any balance to the WSD Human Resources Department otherwise I will be held responsible for the charges. I understand that COVID-19 is a reportable disease such that testing information including name and results will be forwarded to my local health department and possibly my child's school/district nurse. . I authorize the staff at Tosa Pediatrics to leave a voicemail at the number below with my test results.

Signature _____ Phone_____ Date_____

Please answer the following questions. If the questions are unclear, please ask your healthcare provider.

1. Have your child been exposed to anyone who tested positive for COVID-19 OR is waiting for test results? _____ Yes _____ No _____Unsure

   If yes, when was the last exposure to that person? _____ days ago

2. Does your child currently have any symptoms? _____ Yes _____ No _____Unsure
   If yes, when did they first start? Please list symptoms:
   _____ _____

3. Where does your child attend school(s) or daycare? _____ Yes _____ No _____ N/A

   _____ Grade/Room_____

4. Is this your child's first ever COVID swab test? _____ Yes _____ No

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Office use only:

Temp _____ F Pertinent findings: _____

_____

Test sent to: _____ Tosa Peds _____ WDL _____Acutis _____Other

Signature: _____ Date: _____

Result: _____ POS _____Neg Notified of result, isolation guidelines: _____

Entered into database: _____ Init:_____ Date: _____

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