San Benito County Public Health Services

COVID-19 Rapid Test Report Form

Information for person being tested.

Name:

Phone:

Test date (mm/dd/yyyy)**:**

Sex:

Symptom start date (mm/dd/yyyy)**:**

◯ None

Address:

DOB (mm/dd/yyyy):

Exposure date (mm/dd/yyyy)**:**

◯ Not Applicable

Primary Language (check one)**:**

◯ English
◯ Spanish
◯ Other (specify):

Ethnicity (check one)**:**

◯ Hispanic/Latino
◯ Non-Hispanic/Non-Latino
◯ Unknown

Race (check all that apply)**:**

◯ White
◯ Asian
◯ Pacific Islander
◯ Unknown
◯ African-American/Black
◯ American Indian/Alaska Native
◯ Other (specify):

Symptoms (check all that apply)**:**

◯ Fever (>100.4°F, 38°C)
◯ Subjective fever (feverish)
◯ Cough
◯ Sore throat
◯ Body aches
◯ Abdominal pain
◯ Diarrhea
◯ Headache
◯ Nausea
◯ Vomiting
◯ Chills
◯ Lethargy/fatigue
◯ Loss of smell
◯ Loss of taste
◯ Runny nose
◯ Shortness of breath
◯ Difficulty breathing
◯ Dermatologic finding
◯ Other (specify):

Chronic Conditions (check all that apply)**:**

◯ None
◯ Unknown
◯ Asthma
◯ Cardiovascular disease
◯ Chronic lung disease
◯ Stroke, DVT
◯ Hypertension
◯ Diabetes
◯ Chronic kidney disease
◯ Neurological/neuro-developmental
◯ Obesity
◯ Chronic liver disease
◯ Immunocompromised
◯ Cancer
◯ Current smoker
◯ Former smoker
◯ Pregnant
◯ Other (specify):

Vaccination History Has person received COVID-19 vaccine?

◯ Yes ◯ No ◯ Unknown

Dose #1 Date: (mm/dd/yyyy)

Dose #1 Type:
◯ Moderna ◯ Unknown
◯ Pfizer ◯ Other:

Dose #2 Date: (mm/dd/yyyy)

Dose #2 Type:
◯ Moderna ◯ Unknown
◯ Pfizer ◯ Other:

Dose #3 Date: (mm/dd/yyyy)

Dose #3 Type:
◯ Moderna ◯ Unknown
◯ Pfizer ◯ Other:

Employer/Agency:

Address:

Name of Person Filling Form:

Phone Number:

Test Type:

◯ Abbott BinaxNOW
◯ BD Veritor
◯ Quidel Sofia
◯ Unknown
◯ Other:

TEST RESULT:

◯ Negative
◯ Positive
◯ Indeterminate
◯ Not Tested

PLEASE EMAIL THIS FORM TO:

covid@cosb.us

OR FAX:

Attn: Epidemiology

(831) 637-9073