FAMILY HEALTH CARE ASSOCIATES

TEST: _____ DATE: _____

NAME: _____ DOB: _____

CHIEF COMPLAINT: SCREENING/ ENCOUNTER FOR COVID- 19

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

DATE SYMPTOMS BEGAN: _____

FEVER	YES/ NO	VOMITTING	YES/ NO
SORE THROAT	YES/ NO	COUGH	YES/ NO
LOSS OF SMELL/TASTE	YES/ NO	SHORTNESS OF BREATH	YES/ NO
DIARRHEA	YES/ NO	FATIGUE	YES/ NO

HAVE YOU TRAVELED OUTSIDE THE US IN THE PAST 14 DAYS? YES/ NO

HAVE YOU HAD DIRECT EXPOSURE TO A PERSON THAT HAS TESTED POSITIVE? YES/ NO

IF SO, WHERE AND WHEN WAS THE EXPOSURE? _____

IS THIS THE FIRST TIME BEING TESTED FOR COVID 19? YES/ NO

HAVE YOU BEEN HOSPITALIZED FOR COVID 19? YES/ NO ICU: YES/ NO

ARE YOU A HEALTH CARE WORKER: YES/ NO

WOMEN: ARE YOU PREGNANT? YES/ NO

PATIENT VACCINATED (COVID 19): YES/ NO

EXAM:

VITALS:

Temp:____ O_2 Sat:_____ Pulse:_____ Resp rate:_____ BP: ____/____ Height: ____ Ft _____ In Weight: ____ lbs.

Any Known Allergies: _____

- GENERAL: No acute distress. Sitting comfortably
- Eyes: No scleral icterus. No scleral injection
- Respiratory: Regular respiratory rate.
- Cardiovascular: Under my supervision, no peripheral edema on self-palpation
- Gastrointestinal: Non-distended. Non tender to self-palpation.
- Musculoskeletal: No joint deformity or effusion.
- SKIN: No obvious rash or ecchymosis

PLAN:

TESTS BEING ORDERED TODAY:

CPT Code	Test	Positive	Negative	Performed By
☐ 87426	Rapid Covid (SARS-CoV)	☐	☐	
☐ 86328	Covid Antibody test	☐	☐	
☐ U0001	nCov RT- PCR (Send out)	☐	☐	
☐ 87804	Rapid Flu A	☐	☐	
☐ 87804	Rapid Flu B	☐	☐	
☐ 87880	Rapid strep	☐	☐	

Patient instructed on symptomatic treatment, including but not limited to, rest, drink fluids regularly to avoid dehydration, use of over-the-counter medicines to manage fever, headache, myalgias, and cough. Patient was instructed to return to the clinic or go to the nearest emergency room should symptoms worsen.

ADDITIONAL ORDERS OR RECOMMENDATIONS:

_____

_____

_____ _____

Provider Signature Date

REPORATABLE TO HEALTH DEPARTMENT: YES/NO

REPORTED BY: _____ DATE REPORTED: _____ COUNTY: _____

Test To Stay Information and Permission Form

The Test to Stay Program will allow students who have been identified as a close contact to avoid quarantine if they test negative.

What is the Rapid Test C19 (COVID-19)? If your child is identified as a close contact of a positive Covid-19 case, you may provide permission for your child to be tested. If your child tests negative on the first day of known exposure, then your child may stay at school for that day. Testing negative for the next four consecutive school days and being asymptomatic will allow your child to remain at school to receive uninterrupted education and avoid quarantine.

If you consent, your child will receive a free rapid test for the COVID-19 virus. Collecting a specimen for testing involves using a swab, similar to a Q-Tip, placed inside the nose. In collaboration with Family Health Care, a trained health care professional who has been trained to administer this test will collect the sample.

The Rapid Test results are available within 25 minutes. A printed copy of test results will be made available typically within 24 hours to the parent/guardian who signs this permission form below. This program is optional for our students however we hope you choose to have the test to keep our schools as healthy and safe as possible and allow your child to remain in school. The tests are being offered in addition to existing safely protocols such as mask-wearing, social distancing, and frequent disinfection of surfaces. Only students who have parent/guardian permission and are identified as close contacts to a positive case at school have the option to be tested.

What should I do when I receive my child's test results? If your child or you (if a student is age 18 or older) tests positive for the virus, your child will be moved to a room away from other students and staff until you can pick him/her up. Students who test positive are quarantined until the infection period has ended (10 days from the date symptoms first appear) and your child is no longer contagious. If your child's test results are negative, the virus was not found in the specimen tested and your child may continue to attend school without interruption. In a small number of cases, tests sometimes produce incorrect results – showing negative results (called 'false negatives") in people who have COVID-19 or showing positive results (called "false positives") in people who don't have COVID-19. If your child tests negative but has symptoms of COVID-19 or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor or a licensed medical authority, or your County Health Department.

*This permission form is only to administer a **COVID-19 test**. It is NOT permission for any other related services. This permission form is **NOT** permission for COVID 19 Vaccination.
**Disclaimer: While we realize precautions will be taken for the safety of students, please understand that neither the Test Administrator nor the school's BOE and District, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to your child or yourself (if student aged 18 or older) as a result of agreeing to the test.

By signing below, I attest that:

A. I authorize the school system to conduct collection and testing of my child or me (if student age 18 or older) for COVID-19 by nasal swab.
B. I acknowledge that a positive test result is an indication that my child or me (if student age 18 or older), must self-isolate and also continue wearing a mask or face covering as directed in an effort to avoid infecting others.
C. I understand the School System is not acting as my child's medical provider, This testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree to seek medical advice, care, and treatment from my child's medical provider if I have questions or concerns, or if their condition worsens.
D. 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, 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.

CONSENT

PATIENT (STUDENT) NAME : _____ DATE OF BIRTH: _____
PLEASE PRINT LEGIBLY

PARENT SIGNATURE: _____ DATE: _____
OR GUARDIAN

Parent Printed Name: _____
OR GUARDIAN PLEASE PRINT LEGIBLY

STUDENT SIGNATURE: _____ DATE: _____
(If age 18 or otherwise authorized to consent)