



# COVID-19 Testing Questionnaire - CHILD

Name (Last, First): \_\_\_\_\_ DOB: \_\_\_\_\_

Cell Phone : \_\_\_\_\_ Email : \_\_\_\_\_

Do you want your results emailed?  Yes  No If yes, will send to email listed above.

I understand that if my insurance is different from that of my child, I must provide my personal insurance. I understand that if my insurance does not cover the cost of the COVID-19 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 school/district nurse. I authorize the staff at Tosa Pediatrics to leave a voicemail or text at the number above with any test results.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

1. Has 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 or did your child have any of the following symptoms?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fever or Chills      | <input type="checkbox"/> Cough                      | <input type="checkbox"/> Shortness of breath/ difficulty breathing |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Sore throat                | <input type="checkbox"/> Congestion or runny nose                  |
| <input type="checkbox"/> Muscle or body aches | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Headache                                  |
| <input type="checkbox"/> Nausea or vomiting   | <input type="checkbox"/> New loss of taste or smell |  |

If yes, when did they first start? \_\_\_\_\_

3. Does your child attend school or daycare? \_\_\_\_\_ Virtual \_\_\_\_\_ Hybrid \_\_\_\_\_ In person \_\_\_\_\_ N/A

Where? \_\_\_\_\_ Grade \_\_\_\_\_ Cohort \_\_\_\_\_

4. Is your child a patient at Tosa Pediatrics? \_\_\_\_\_ Yes \_\_\_\_\_ No

5. Is your child fully vaccinated for COVID-19? \_\_\_\_\_ Yes \_\_\_\_\_ No

6. Ethnicity: Hispanic or Latino:  Yes  No  Unknown  Decline to Answer

7. Race:  American Indian/Alaskan Native  Asian  Black/African American  Black/Trinidadian  
 Native Hawaiian/Pacific Islander  White  Unknown  Other  Decline to Answer

**Office use:**

Temp \_\_\_\_\_ F Pertinent findings: \_\_\_\_\_

Test sent to: TP WDL TPL RN/MA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Result: \_\_\_\_\_ POS \_\_\_\_\_ Neg Notified of result, isolation guidelines (if indicated): \_\_\_\_\_

Entered into database:  If positive, faxed:  Reported to state:  Init: \_\_\_\_\_ Date: \_\_\_\_\_