1234 2nd Ave S, Okanogan, WA 98840 *www.okanogancountycovid19.org* (509) 422-7140

**Patient Name** ______________________________
*First* *Middle* *Last*

*If Patient is a Minor, Parent's Name* ______________________________
*First* *Middle* *Last*

Birth Date ______ / ______ / ________ Age today______ Gender ❑ Male ❑ Female

**Phone number** ( _____ ) ________________ Msg phone ( _____ ) ________________

Primary Language ❑ English ❑ Spanish ❑ Other Interpreter needed? ❑ No ❑ Yes

Primary Care Provider *(PCP)*____________________ Location ______________
*Clinic name / City*

**Physical Address**______________________________ Camp #__________

City______________________ State_____ Zip_________ County______________

PO Box_________ City____________ State_____ Zip_________ County______________

Residence type (incl. Homeless) ______________________________ ❍ H2A Visa

WA state resident? ❑ No ❑ Yes How many other people do you live with? ______

**Name of Employer / School** ______________________ Last date Attended __________

Employer / School Phone # ________________ Supervisor's / Teacher's Name ______________

**Positive COVID-19 test?** ❑ No ❑ Yes; Date(s) __________ **Received COVID-19 vaccine?** ❑ No ❑ Yes

**Signs / Symptoms**

Date Symptoms Started: ___________

Date Isolation Ended: ___________

- ❍ **None**; *none of the symptoms listed below*
- ❍ Fever: △ Subjective
  △ Measured; Temp = ________
- ❍ Chills
- ❍ Headache
- ❍ Muscle aches or pain
- ❍ Sore throat
- ❍ Cough
- ❍ Dyspnea (shortness of breath)
- ❍ Nausea
- ❍ Vomiting
- ❍ Diarrhea
- ❍ Abdominal pain or cramps
- ❍ New onset loss of taste / smell
- ❍ Other symptoms consistent with this illness;
  Specify = ______________________
  ______________________

**Recent contact with a person confirmed to have the COVID-19 / SARS-CoV-2?**

❑ No / Unknown ❑ Yes; Date__________

*If Yes, please list name(s) below!*

| Name | Relationship |
|---|---|
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**Ordering Provider**______________________ Location______________________
*Clinic name / City*

**Authorization to Disclose COVID 19 Test Results to Second Party**

Verbal permission given to share COVID-19 results with anyone who answers the phone number(s) provided on this form. ❑ No ❑ Yes *Details, if any*: ______________________

*Please FAX to (509) 422-7152*