



CONFIDENTIAL FAX 509.422.7152
Please PRINT CLEARLY

OKANOGAN Positive COVID-19 Home Test

This form is available to fill out online at okanogancountycovid19.org/home-test-for-covid

Name _____ If <18 yo, Parent Name _____

DOB _____ Age TODAY _____

Primary Language English Spanish Other

Phone Number (_____) _____

Physical Address

Street _____

City, State, ZIP _____

Employer or School _____

Level of COVID-19 vaccine received

- 1st
- 2nd
- 3rd / Booster
- 4th / 2nd Booster
- 1st only & Booster
- Initial vaccines(s) & multiple boosters
- None

Number of previous COVID-19 infections (Do not include this event) _____

Date SYMPTOMS began _____

Name / Brand of Home or OTC Test _____

Date of POSITIVE COVID-19 Test _____

Check all symptoms experienced with this infection:

- NONE (No symptoms / Asymptomatic)
- Brain Fog / Confusion
- Cough
- Dizziness / Vertigo
- Fever
- Muscle aches or pain
- Runny nose
- Shortness of breath (Dyspnea)
- Vomiting
- Abdominal pain or cramps
- Chills
- Diarrhea
- Fatigue
- Headache
- Nausea
- Sore or scratchy throat
- New onset of loss of Taste / Smell
- Other _____

Name of PCP / Doctor _____

State / Verbal acknowledgment: Are you voluntarily reporting your positive COVID-19 Home Test result to Okanogan County Public Health District (OCPHD) and understand that you may be contacted for Contact Tracing purposes? Yes No >>> **Do NOT fax to OCPH!**

Reported to OCPH by _____