Premier Medical Group USA

COVID-19 Test Registration (Name of School District)

Patient Information

First Name		Street Address (Home)	
Last Name		Apt/Unit	
Mobile Number		City	
Email Address		State/Zip	
Date of Birth *(MM/DD/YYYY)*		Gender	

Parent/Guardian Information *(if applicable)*

First Name		Mobile Number	
Last Name		Email Address	

School Information

School Name		Grade Level	

Have you previously been tested for COVID-19?

- ◯ Yes
- ◯ No

Have you had a fever in the last 24 hours (over 100.4 F)?

- ◯ Yes
- ◯ No

What were your test Results?

- ◯ Negative
- ◯ Inconclusive
- ◯ Positive

Are you a Student?

- ◯ Student
- ◯ Teacher, Staff
- ◯ Other: _____

Have you been in close physical contact in the last 14 days with anyone who has laboratory-confirmed COVID-19 or has any symptoms consistent with COVID-19?

- ◯ Yes
- ◯ No

Have you traveled outside the USA within the past 10 days?

- ◯ Yes
- ◯ No

Premier Medical Group USA

In the past 24 hours, have you experienced: *(mark all that apply)*

- ◯ Chills
- ◯ Congestion
- ◯ Cough that is abnormal and NOT due to chronic or seasonal allergies
- ◯ Diarrhea
- ◯ Excessive or unusual fatigue that is NOT due to workouts or competition
- ◯ Fever
- ◯ Headache
- ◯ Aches and pains that are unusual and NOT due to workouts or competition Cough that is abnormal and NOT due to chronic or seasonal allergies
- ◯ Loss of sense of smell (new or worsening)
- ◯ Loss of sense of taste (new or worsening)
- ◯ Nausea
- ◯ Rash (new or worsening)
- ◯ Red eyes
- ◯ Runny or stuffy nose that is abnormal and NOT due to chronic or seasonal allergies Shortness of breath that is unusual and NOT due to a chronic condition
- ◯ Shortness of breath (chest heaviness) that is unusual and NOT due to a chronic condition
- ◯ Sore throat that is abnormal and NOT due to chronic or seasonal allergies
- ◯ None of the Above

COVID-19 Testing: Informed Consent

Please carefully read and sign the following Informed Consent: I authorize Premier Medical Group to conduct collection and testing for COVID-19 through a Nasal swab, as ordered by an authorized medical provider. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I understand that Public Health authorities may contact me directly should I test positive. I acknowledge that a positive test result is an indication that I must self-isolate in an effort to avoid infecting others. I understand the testing unit is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens. 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, possible 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 informed that I can ask additional questions at any time.

- ◯ I would like to receive a copy of the Informed Consent.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I understand that COVID-19 safety measures, including detection and contact tracing are an important part of safety at in-person events during the current pandemic. This is why I am making the following requests, authorizations, and statements.

I authorize Dr. Scott Miscovich and Premier Medical Group USA to disclose to: Name of School District and its affiliates; The COVID-19 Authority associated with the location where I am being tested; and Any person or entity assisting Name of School District and its affiliates with contact tracing efforts.

The following information: health records related to any COVID-19 testing conducted on or after the date hereof, including any and all personal information collected in connection with such testing. Information released shall be limited to the results of COVID Testing performed unless otherwise specified by the patient.

The purpose of the disclosure authorized herein is to: Convey the results of the COVID-19 testing to Name of School District and its affiliates so they may use and disclose such information as they deem reasonably necessary, including but not limited to, making determinations of attendance, contract tracing, and reporting to public health authorities.

I understand that if my test result indicates that I am positive for the COVID-19 virus, I will need to follow the guidelines established by Name of School District and its affiliates to prevent further transmission of the virus.

I understand that to the extent my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164, this document authorizes the release of my records as indicated herein.

I further understand that for the purposes disclosed above, the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and that re-disclosure may not be prohibited by the HIPAA privacy law.

I understand that I may revoke this authorization in writing to info@pmgusa.org at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically one year from signature date. I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization. I understand that I am entitled to receive a copy of this authorization after it is signed.

◯ I would like to receive a copy of the HIPAA Release Form and Informed Consent.

Signature _____ Name _____

Patient or Legal Guardian *Patient or Legal Guardian (Print)*

Date of Signature _____ _____ _____

MM *DD* *YY*