XPRESS URGENT CARE
WALK IN CLINIC

COVID History form (Pediatric)

A. **Student's Information:**

1 Name: Last: _____ First: _____ Middle: _____

2. Date of Birth: _____/_____/_____

3. Birth Gender: ☐ Male ☐ Female

B. **Student's Current Symptoms:**

1. CURRENTLY has fever/chills	☐ Yes	☐ No	
2. CURRENTLY have shortness of breath	☐ Yes	☐ No	(IF YES PLEASE CALL 911 OR GO TO ER)
3. CURRENTLY has cough	☐ Yes	☐ No	
4. CURRENTLY has chest pain	☐ Yes	☐ No	(IF YES PLEASE CALL 911 or GO TO ER)
5. New onset loss of taste or smell	☐ Yes	☐ No	
6. Body aches	☐ Yes	☐ No	
7. Nasal congestion, sore throat, runny nose	☐ Yes	☐ No	

8. Other current symptoms : _____

C. **Student's <u>Active</u> Medical Conditions:**

1. Asthma/COPD	☐ Yes	☐ No
2. Diabetes	☐ Yes	☐ No
3. Cancer	☐ Yes	☐ No
4. Autoimmune disease	☐ Yes	☐ No
5. Heart Disease	☐ Yes	☐ No

6. Other Chronic Medical Conditions: _____

C. Medications Student takes daily:

☐ Student is currently **not** on any medications

☐ Student's list of medications are : _____ _____ _____

_____ _____ _____

G. Medication student is allergic to

☐ Student has no known medication allergies

☐ Student is allergic to these medications: _____ _____ _____

C. Student's Social History:

Student lives with : ☐ Parent(s) ☐ Grandparent(s) ☐ Other: _____

Grade level : ☐ Elementary ☐ Middle ☐ High School

By placing my signature below, I hereby certify that the information I provided above about the student is true and correct.

Parent's Name: _____

Signature: _____ *Date:* _____/_____/_____

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Permission to Test for Covid

Lab test requested by Zaid Noman, MD Diagnostic Code:Z20.828

TWO COPIES NEEDED. DO NOT STAPLE ANYTHING TO THIS PAGE.

A. Student's Information:

Child's Name: _____
LAST NAME FIRST NAME DOB (MM/DD/YYYY)

Parent's Name: _____
LAST NAME FIRST NAME DOB (MM/DD/YYYY)

Address: _____ City: _____ Zip: _____

Birth Gender (circle one) ☐ M ☐ F Phone#: _____

Email: _____ Ethnicity: _____

B. Bill test to: ____Insurance ____No Insurance

Medical Insurance: _____
(Anthem, Blue Shield, Kaiser, Healthnet, United Healthcare, etc.)

Medical Group: _____
(Prospect, Healthcare Partners, Monarch, Regal, LA Care, etc.)

Insurance# _____

Group# _____

Provide two copies of your Photo ID and the front and back of your insurance card. DON'T STAPLE

School Name: _____

C. Requester Authorization:

I agree to allow my child to be tested for Covid-19 infection (Corona Virus) test

Printed Name: _____

Signature*: _____ Date*: _____

YOUR RESULTS WILL BE AVAILABLE WITHIN 48-72 HOURS. PLEASE REGISTER AT LabCorp Patient Portal TO RECEIVE A TEXT/EMAIL WHEN YOUR RESULTS ARE READY. IF YOU HAVE QUESTIONS, EMAIL RESULTS@XURGENTCARE.COM WITH YOUR FULL NAME AND DOB.

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