



Riley's Drugs
1207 W. Main Street
Lexington SC 29072
803-359-2587

COVID-19 TESTING PATIENT CONSENT FORM

Name: _____ Date of birth: _____

Address: _____ City: _____

County: _____ State: _____ Zip code: _____ Last 5 digits of SSN: _____

Phone number: _____ Gender: Male Female Pregnant Y / N

Allergies: _____ Pre-existing Diseases/Conditions: _____

Primary care provider name: _____ Phone: _____

How would you best describe your race? Please select all that apply. If you would prefer not to answer this question, you may leave it blank.

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Other race | <input type="checkbox"/> White |

Have you had a direct exposure to COVID-19? Yes No Unsure

Approximately how many days ago were you exposed to COVID-19? _____

What symptoms are you experiencing now? Please select all that apply.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Muscle or body aches | <input type="checkbox"/> Headache | <input type="checkbox"/> New loss of taste or smell | <input type="checkbox"/> Sore throat/ Hoarseness |
| <input type="checkbox"/> Congestion or runny nose | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> No symptoms |

For how many days have you been experiencing symptoms? _____

Do you work in a healthcare setting? Y / N

Do you live in a long term care facility? Y / N

By signing the line below, I give consent to Riley's Drugs to send my testing results to the South Carolina Department of Health and Environmental Control (DHEC).

Patient signature: _____ Date: _____

-----**FOR STAFF USE ONLY**-----

Car make/ model/ color _____ Credit card #: _____ Exp: _____

Type of test: Rapid Antigen Antibody

Date Administered _____ Time Tested _____ Time Read _____

Lot # _____ Exp: _____ Result: _____

Administered by _____ Signature _____ License # _____