School Testing Request Form

Full Name: ___________________________________________  Date of Birth: ____________________

Address: ___________________________________________  Phone: _____________________________

Parent/Guardian Full Name: ______________________________________________________________

School District: ______________________________________________________________________

Symptoms (please circle all that apply):
• Shortness of breath or difficulty breathing  • New loss of taste or smell  • Cough

Or at least two of these symptoms:
• Fever  • Headache  • Muscle or body aches  • Fatigue
• Sore throat  • Runny Nose  • Congestion  • Nausea
• Vomiting  • Diarrhea

The following questions are required for all Covid-19 tests that are collected for reporting to the Iowa Department of Public Health. Please answer all questions or circle the appropriate answer.

1) Is this test for diagnosis or screening?  Diagnosis  Screening  
***This test is not to be used for screening purposes.
2) Date of symptom onset? __________________
3) Hospitalized for Covid-19?  Yes  No
4) Admitted to ICU for Covid-19?  Yes  No
5) Employed in a healthcare setting?  Yes  No
6) Resident in congregate (group) setting?  Yes  No
7) Are you pregnant?  Yes  No  Unknown  Not applicable
8) Is this the first Covid-19 test you’ve had collected?  Yes  No

Please call Cherokee Regional Medical Center Laboratory to schedule your Covid-19 test collection.  712-225-1514
If you would like to be seen by a provider for your illness, please call Cherokee Regional Clinics to schedule an appointment.  712-225-6265.