CHEROKEE REGIONAL MEDICAL CENTER

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 <u>required</u> 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.