VERMONT
DEPARTMENT OF HEALTH

COVID Test Registration and Result Form

Patient Information

Patient Name*	First		Last	
Date of Birth*				
Administrative Sex*	Male	Female	Other	Unknown
Street Address				
City, State and ZIP*				
Phone number				
Patient Race (please circle)	American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander		White Other Race Unknown	
Patient Ethnicity (please circle)	Hispanic or Latino	Not Hispanic or Latino	Unknown	
Circle any symptoms you are experiencing. If none, select "**No Symptoms**"	**No Symptoms** Fever over 100.4F Feeling feverish Chills Cough Shortness of breath	Difficulty breathing Fatigue Muscle or body aches Headache New loss of taste New loss of smell	Sore throat Nasal congestion Runny nose Nausea Vomiting Diarrhea	

For Office Use

Date of Test (MM/DD/YYYY): _____ / _____ / _____

Time Started: _____ Time Read: _____

Test Result (please circle): Positive Negative Invalid Inconclusive

Result read by (staff name): _____