YOU MUST RETURN THIS SHEET TO RECEIVE YOUR TEST RESULTS
(PLEASE PRINT CLEARLY)

ALLEN COUNTY PUBLIC HEALTH

Testing Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone for Results: _____

Email Address: _____

I consent to the taking of a nasopharyngeal sample for testing for the SARS-CoV-2 virus that causes COVID-19 disease, as indicated by my entering my full name in the space below. (If patient is under 18 years of age Parent or guardian should sign)

_____ _____
Signature Date

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