VERBAL CONSENT AND INTAKE FORM

Today you are undergoing specimen collection for COVID-19 and providing your consent for official use of your test results as defined in the handout provided to you.

Eligibility Criteria for Testing (Circle applicable criteria; Minimum age 5 years; Parental consent for ages 5-17 years):

1. Individuals who have symptoms suggestive of COVID-19, including any one of the following:
    a. Fever, defined as a measured temperature greater than 100.4F
    b. Subjective fever, for example if a person feels unusually warm to the touch, or reports sensations similar to previous experiences of fever
    c. Cough
    d. Shortness of breath or difficulty breathing
    e. Fatigue
    f. Sore throat
    g. Headache
    h. Chills or rigors (repetitive shaking chills)
    i. Myalgia (muscle aches)
    j. New loss of taste or smell
    k. Congestion or runny nose
    l. Nausea or vomiting
    m. Diarrhea
2. Individuals ages 5 and older without symptoms who have been referred to a testing site by a clinician or representative of a state or local public health agency, as part of a public health investigation or effort to contain known community spread.

Your Verbal Consent Means That You Agree With The Following:

- You are eligible for testing under the criteria described above and you are requesting to (or you are requesting that your minor child) have COVID-19 testing completed;
- You understand that your test result and protected health information, while not disclosed publicly, will be provided to and used by the Wisconsin Department of Health Services and local public health as needed to better understand and manage the COVID-19 outbreak. Your test result may also be conveyed to your treating provider or the ordering physician, as well as the Wisconsin National Guard to make result notifications.
- You understand that we will use the phone number and email that you provide to contact you with information on how to access your test results online.
- You understand that a maximum of two attempts will be made to contact you by telephone with the test results within 3-7 days and that thereafter it is your responsibility to call your local health department for results . Alternatively, you may access your results online.

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To Be Completed By Service Member:

First Name: _____ **Last Name:** _____ **Date of Birth:** ___/___/_____

Phone 1: _____ **Phone 2:** _____ **County:** _____

Street Address: _____ **City:** _____ **Zip Code:** _____

Name of Parent (If A Minor): _____

Individual has verbally provided informed consent to participate in this testing.	Yes	No
Individual verbalized understanding of the authorization.	Yes	No
Individual was provided a copy of the privacy notice.	Yes	No

_____ _____
Signature of Service Member Doing Intake Date

_____ _____
Printed Name of Service Member Doing Intake Date