SPECIAL APPOINTMENT FORM

****Required to be completed in its ENTIRETY before arriving for appointment.****

BinaxNOW Testing Patient Information

Please complete **ALL** information below legibly so we can maintain compliance with all state regulations and continue to provide this service.

Last Name:_____ **First Name**:_____

School/Department: _____ **Supervisor:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ Decline to say ☐ Unknown

Race:

☐ American Indian/Alaska Native American Indian/Alaska Native
☐ Black/African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ White/Caucasian

Ethnicity:

☐ Hispanic
☐ Latino/a
☐ Unknown
☐ Decline to say

Street Address:_____

City:_____**State:** _____ **Zip code:** _____

Phone Number: _____

For WCSD notification purposes only:

Email Address: _____@washoeschools.net **– OR –** _____

Testing Personnel Only: ☐ Positive ☐ Negative ☐ Notified _____