Licking County
Health Department
675 Price Road ▪ Newark, Ohio 43055
Business: (740) 349-6535 ▪ Fax: (740) 349-6510
www.LickingCoHealth.org

Licking County Health Department COVID-19 Testing Consent Form

(To be filled out by LCHD)

NURSE: ____ DATE: ____________________

(To be filled out by patient)

PATIENT NAME: DATE OF BIRTH:

MALE FEMALE SSN:

ADDRESS: CITY:

STATE: ZIP: COUNTY:

PHONE NUMBER: EMAIL ADDRESS:

INSURANCE:

RACE: WHITE ASIAN BLACK HAWAIIAN NATIVE OR PACIFIC ISLANDER

AMERICAN INDIAN OR ALASKAN NATIVE REFUSE TO ANSWER

UNKNOWN OTHER:

ETHNICITY: HISPANIC OR LATINO NON-HISPANIC OR LATINO REFUSE TO ANSWER

DO YOU WORK OUTSIDE OF THE HOME? YES NO

ARE YOU A HEALTHCARE WORKER OR 1ST RESPONDER? YES NO

IF YES TO EITHER QUESTION, WHERE DO YOU WORK?

EMPLOYER ADDRESS:

OCCUPATION:

DID YOU WORK WHILE ILL? YES NO LAST DATE WORKED:

DO YOU LIVE IN A CONGREGATE SETTING? (long-term care, shelter, group home, prison, jail) YES NO

DO YOU RECEIVE DIALYSIS OR WORK IN A DIALYSIS FACILITY? YES NO

ANY KNOWN ESPOSURE TO A PERSON DIAGNOSED WITH COVID-19? YES NO

IF YES, NAME OF PERSON:

COUNTY THIS PERSON RESIDES IN: DATE OF EXPOSURE:

(Please see next page)

Licking County
Health Department

675 Price Road ▪ Newark, Ohio 43055
Business: (740) 349-6535 ▪ Fax: (740) 349-6510
www.LickingCoHealth.org

WHAT SYMPTOMS, IF ANY, ARE YOU CURRENTLY EXPERIENCING?

FEVER	LOSS OF TASTE/SMELL	CHILLS
NAUSEA OR VOMITING	COUGH	DIARRHEA
SORE THROAT	ABDOMINAL PAIN	MUSCLE ACHES
RUNNY NOSE	HEADACHE	OTHER

---

1) I am the patient named above or I am the parent or legal guardian (if the patient is a minor or dependent) of the patient named above.
2) I authorize the Licking County Health Department to collect a specimen for COVID-19 testing.
3) I understand it is my responsibility to determine how COVID-19 services are covered by my insurer.
4) I understand there are two methods of collection offered, with preference given to anterior nares (nasal swab), depending on availability of testing supplies.
5) I understand the anterior nares collection [preferred method] procedure and possible risks:
    a. Using a flocked or spun polyester swab, insert the swab at least 1 cm inside the nostril (naris) and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 to 15 seconds. Sample both nostrils with same swab.
6) I understand the nasopharyngeal collection procedure and possible risks:
    a. A thin cotton tip applicator is passed deep into the nasal passages
    b. The test may be uncomfortable and may trigger coughing and sneezing
    c. Some bleeding after the collection may occur, but is not expected
    d. Failure to obtain a deep swab may result in inaccurate test results
7) The Licking County Health Department will collect and send the specimen to LabCorp, Quest Diagnostics, or the Ohio Department of Health Laboratory for laboratory analysis and report of my, my child’s, or dependent’s specimen. I authorize LabCorp and/or Quest Diagnostics to perform testing.
8) I understand the COVID-19 test is not 100% accurate, cannot be used to rule out an infection, and a negative test does not preclude the presence of COVID-19.
9) I understand that results are generally available within 48-72 hours but may be longer due to lab volume and processing times.
10) I understand a Licking County Health Department staff member will contact me only at the number provided on this consent whether the result is positive or negative. Positive results for COVID-19 are reported to the Ohio Department of Health.

(Please see next page)

11) I understand that Licking County Health Department will be responsible for providing testing results, interpreting test results, explaining testing limitations, and facilitating any additional diagnostic or clinical services.
12) I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
13) I acknowledge that a positive test result is an indication that I must self-isolate in an effort to avoid infecting others.
14) I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

PRINT NAME PATIENT SIGNATURE DATE