Family Pharmacy Clinical Services

Health Test Consent Form

Which test(s) are you requesting today? (Check all that apply)

☐ Blood Pressure ☐ Cholesterol Panel ☐ Blood Glucose ☐ Hemoglobin A1C

☐ COVID-19 Rapid Antigen ☐ COVID-19 Antibody ☐ Influenza A/B Rapid

Patient Name: _____ **Date of Birth:** ____/____/_____

First MI Last MM/DD/YYYY

Sex: ☐ **M** ☐ **F** **Phone:** (_____)_____ **Email Address:** _____ (Optional)

Address: _____

Street or P.O. Box City State Zip

Primary Physician: _____

The following questions will help determine your eligibility.	YES	NO
1.Do you feel sick today? **If yes, please explain:**		
2. Do you have allergies to medications, food, latex, or vaccines? **If so, please list:**		
3. Have you eaten a meal in the last 8 hours?		
4. Do you have any health conditions/diseases (including resolved COVID-19 infection)? **If so, please list:**		
5. Have you been exposed to the Coronovirus in the last 2 weeks?		

Notes: _____

Place Rx Label Here

For Clinic Use Only

Date of Test:_____ Initials:_____

Result(s):

BP: _____Glucose: _____Hem A1C_____

Cholesterol: Total: _____ HDL: _____

LDL: _____ Trig: _____

COVID-19 Antibody: IgM:_____IgG:_____

COVID-19 Rapid Antigen: Pos_____Neg_____

Influenza A: Pos____Neg_____ **B:** Pos____Neg_____

LOT: _____ **EXP:**_____

I certify that I am the patient and at least 18 years of age, or the legal guardian of the patient. Further, I give my consent to the healthcare provider of Family Pharmacy to administer the test(s) I have requested above, and draw a finger stick blood sample and/or collect anterior nasal swab(s) if necessary. I understand the benefits and risks of receiving the above test(s), and I have been given the opportunity to ask any questions that I may have. I hereby release Family Pharmacy and all officers, directors, and employees from any and all liability arising from or in any way related to the administration of the test(s) listed above. I acknowledge that I have received and reviewed a copy of Family Pharmacy's Notice of Privacy Practices.

Signature: _____ **Date:**_____