RI Department of Health COVID Testing reporting form

First Name_____ **Last Name**_____**Birth Date** _____
Address: _____
_____
_____

Gender: Female: Male: Other

Race (Circle all that Apply)
American Indian or Alaska Native
Black or African American
White
Asian
Native Hawaiian or Other Pacific Islander
Hispanic Ethnicity
Not Specified
Don't Know
Declined
Other Race

Nationality (Select all that Apply)
American
Asian
Cambodian
Cape Verdean
Chinese
Columbian
Congolese
Dominican
English
Ethiopian
Filipino
French
German
Ghanaian
Guatemalan
Hmong
Indian
Irish
Italian
Korean
Laotian
Lebanese
Liberian
Mexican
Nigerian
Polish
Portuguese
Puerto Rican
Russian
Salvadoran
Scottish
Somalian
Syrian
Taiwanese
Vietnamese
Other

Primary Language _____

Phone Number _____

Email _____

Are you affiliated with an Education Setting? Yes no
If so…

Childcare, K-12, Higher Ed (University/College), Higher Ed (Technical), Higher Ed (Military)

School Name _____
School Affiliation: Student, Staff, Other
Learning Style: In Person, Virtual, Hybrid

COVID-19 SYMPTOMS
Select all that Apply:

No Symptoms
Cough
Shortness of breath or difficulty breathing
Fever
Chills
Muscle pain
Sore Throat
Headache
Nausea
Vomiting
Diarrhea
Runny nose
Fatigue
Recent loss of taste
Recent loss of smell
Congestion

Symptom Onset Date :

To Be Completed by Staff

Test Date_____

Test Time_____

Test result_____