VALLEY HEALTH TEAM
LIVE BETTER. VIVE MEJOR.

COVID-19 TESTING

Instructions for the person completing this form:

Please ensure all information is complete and legible; this will ensure the correct information is on the lab sample. Thank you.

FIRST NAME: _____

MIDDLE NAME: _____

LAST NAME: _____

PHONE #: _____ GENDER: ☐ M ☐ F Other: _____

BIRTHDATE (month/date/year): _____

ADDRESS: _____

COUNTY: _____

PLACE OF EMPLOYMENT: _____

VEHICLE DESCRIPTION: _____

MARK ANY SYMPTOMS YOU HAVE:

☐ Fever ☐ Cough ☐ Shortness of Breath ☐ Headache ☐ Muscle Aches/Pain ☐ Other

INSTRUCTIONS FOR THE DAY OF TESTING:

- Please display your Driver's License or CA Identification Card to traffic and testing staff. This will help us ensure the correct information is on your lab sample.

- Please keep WINDOWS UP until you reach the staff wearing a gown and mask.