BinaxNOW Test Registration Form

NOTE: If multiple people from your household are testing at the same time, please indicate:

How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Section 1. Please tell us about yourself. Your responses are confidential and only shared with the RI Department of Health.***

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

Contact Telephone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you from Hispanic, Latino or Spanish origin? \_\_ Yes \_\_ No \_\_ Don't Know/Not Sure

Which of the following is your race? (Check one)

\_\_ American Indian or Alaskan Native

\_\_ Asian

\_\_ Black or African American

\_\_ Native Hawaiian/Pacific Islander

\_\_ Hispanic

\_\_ White

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity/Cultural Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How do you self-identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Section II. Please tell us about your COVID history and why you are here today.***

Have you been within 6 feet of an infected person for a total of 15 minutes or more? \_\_ ​Yes \_\_ No

Are you symptomatic? \_\_Yes \_\_ No If yes, list symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need copy of your test results? \_\_ ​Yes \_\_ No If yes, please wait outside or in your car until contacted by someone from the testing team.

If positive, I consent to my results being photographed and sent to me at the contact number above. \_\_ Yes \_\_ No

Language preference for contact? \_\_ English \_\_ Spanish \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Disclaimer: I consent for myself/my child to receive screening for COVID-19 using the BinaxNOW test, which is a type of rapid test that results in about 15 minutes. Specimens will be collected via a nasal swab. These results will be for screening purposes only and a negative result does not guarantee that I am not infected with SARS/COVID 19. My information and test results may be shared with the RI Department of Health, as required by law.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_