



CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

COVID-19 Testing Registration

Name-Last: _____ First: _____ Middle Initial: _____

DOB: _____

Address (physical and mailing):

Phone: (cell) _____

Alternate: _____

Email address: _____

OK to text/email / call with results? (circle)

Race: (circle): Black/AA / Hispanic / White

Gender: (circle): Male / Female

Preferred language: _____

Symptomatic? No / Yes, Symptom start date: _____

Primary Care Doctor: _____

Have you tested previously for COVID-19? (circle) No / Yes

If Yes, reason for testing today: _____

8/6/20 LM

