Alliance Family Health Center COVID

Registration and Consent

PLEASE PRINT CLEARLY

Last Name_____ **Birth Date**_____

UMU ID:_____

First Name_____

Address_____

_____

Phone_____

Demographics:

Ethnicity: ⬭ Hispanic or Latino ⬭ Not Hispanic or Latino

Race: ⬭ White ⬭ Black/African American ⬭ Asian

⬭ American Indian/Alaska Native ⬭ Native Hawaiian/Pacific Islander

Age: _____

Gender: _____

Current Residential Zip Code: _____

__I am already an AFHC patient ___ I want to become an AFHC patient ___ I only want COVID testing

I authorize nasal testing of the above patient for COVID -19. I authorize the release of any medical or other needed information to the health department in the event I have a positive test.

_____ _____

Patient Signature **Date**

Date of Test: _____

Results Date: _____