Client Profile

COVID-19 TESTING

A. Personal Information			Date:
Last Name:	First Name:	MI:	Sex: □ M □ F □ non-binary □ other:
Address:	City:		
Postal Code:	Email:		Cdn Citizen : yes □ no □
Home Tel:	Work Tel:	Cell	**Children Only**
Birth Date: D M Y	Age:	PHN:	Consent Obtained □ Guardian Name: Consent By: Mother □ Father □

B. Test Requirements					
Date of Departure: **D** **M** **Y**			**Time of Travel:**		
Travel Reasons/Work Purposes:					
Final Destination including any stop overs:					
How soon prior to travel does your destination/Country require the test taken	Unknown	72 hours	96 hours	7 days	Other:
Preferred receipt of document	□ email		□ Pick up physical copy		

C. Health Status					
Do any of the following apply to you?	**Yes**	**No**		**Yes**	**No**
Travelled outside Canada in the last 14 days			New Cough		
Known contact with COVID-19 case			Sore Throat		
Fever			Headache		
Fatigue			New sneezing		
Muscle/joint aches			New loss of smell		
Chills			Nausea		
New runny nose/congestion			Vomiting		
New Shortness of Breathe			Diarrhea		
Do you smoke or vape					

Allergies (including: Eggs, Bee Stings, Medications, Yeast, Gelatin, Latex):

Current Medical Conditions:	**Current Medications** including prescription, herbal, over the counter, birth control pills

D. Acknowledgements:

Acknowledge no guarantees:

- I understand that the Clinic cannot guarantee to have results ready before your travel date as there are some things that are not within the Clinic's control.

Acknowledge limitations:

- I understand that the Clinic will not be held responsible if I am denied boarding of my flight or denied entry into my connecting or final destination as a result of the COVID-19 testing conducted by the Clinic and Life Labs, or the Letter of Health provided by the Clinic.

Acknowledge accuracy:

- I understand that the NAAT / RT-PCR COVID-19 test is not 100% accurate.

Name:	Signature:	Date:

For Office use only:
COVID 19 - NASAL SWAB Date:_____ Nurse Signature:_____ TIME:_____
AMOUNT_____CASH / DEBIT / VISA / MC MOA:_____