THE PEDIATRICIANS OF HYDE PARK

______________________________ ___________________ _________________

Patient name: Date of Birth: Today's date:

1. Reason for testing: ____

2. Has your child had a known exposure to COVID 19?

   Please say yes or no: ___________________

   If yes, answer the question A-C If no, skip to number 3.

   Date of exposure: _______________________

   a Is your child vaccinated: ___________________________

      Please say yes or no: ___________________

   b Was your child masked?

      Please say yes or no: ___________________

   c Was your child within 3 feet for at least 15 minutes to this individual?

      Please say yes or no: ___________________

3. Has your child had any of the following symptoms, if yes please list the below: fever, cough, congestion, shortness of breath, headache, nasal congestion, nausea or vomiting, diarrhea or rash?

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4. Is there any additional information your feel important for your doctor to know re: the exposure or need for testing?

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BY FILLING OUT THIS FORM, I CONSENT FOR ONE OF THE DOCTORS TO PROVIDED A TELEHEALTH VISIT AND FOR MY INSURANCE TO BE BILLED FOR THE VISIT.

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Contact Phone Number