COVID-19 Screening Questionnaire and Diagnostic Testing Attestation

To help protect customers and associates, we are asking that all customers complete the following additional screening questions and attestation prior to being evaluated.

We require customers to wear a face mask (*at minimum a disposable, ear loop surgical mask*) during the entirety of the appointment and testing process. If you do not have an appropriate face mask, one will be provided to you at no charge. If you have any condition that prevents you from wearing a mask, please alert the pharmacist and discuss deferring your appointment.

Patient Name:_____ **Date of Birth (M/D/Y):**_____

Please answer the following questions:	**Yes**	**No**
1. In the past **10 days**, have you had close contact with any person when they had an active COVID-19 infection or in the 2 days prior to their first symptoms?		
2. Within the past **24 hours** have you tested negative for COVID-19? A negative COVID-19 test result* is required prior to your appointment for strep throat and/or flu testing. Your test(s) will be canceled by the pharmacy if you DO NOT have a negative COVID-19 test result with you at your appointment. **Acceptable forms of proof for a negative test are:** • Home Antigen result (a photo of the negative result with a date stamp) • Rapid Antigen result (from lab or physician) • Dated PCR result (from lab or physician)		

*If you tested **positive** for COVID-19 in the past **24 hours**, you are **NOT eligible** for a strep or flu test. Please follow-up with your healthcare provider.

Optional telehealth consultations are available for a discounted rate of $49.95 with coupon code "GIANTMARTINS". Visit https://visit.physician360.co/P360/auth/login or scan the QR code to get st

Patient Attestation:

I attest that the above information is true, and the COVID-19 test result that I am presenting (if home antigen test result) is my own and has been conducted **within 24 hours** of my appointment for strep, flu, or other diagnostic testing at GIANT/MARTIN'S Pharmacy.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

(A parent/guardian signature is required for patients who are between 5-17 years of age. Patients who are under 5 years of age are NOT eligible for this service.)