Take Home Test Kit for COVID-19
REGISTRATION FORM

Please provide the following information about the person being tested. Please print legibly in black or blue pen and ensure that all fields are completed. CHEO staff may contact you to confirm information, if required.
By providing your email you are consenting to be contacted via email for the purpose of the COVID-19 test kit.

PART ONE – EVERYONE TO COMPLETE – ALSO PRINT THIS INFORMATION ON THE LABEL

Name (as it appears on the Health Card)	Date of Birth	Sex
First Middle Last	D D / M M / Y Y Y Y	

PART TWO – COMPLETE ONLINE OR THIS FORM

Online: If possible, complete the rest of this registration form online at https://redcap.link/SampleRegistration
You will receive a confirmation email and a registration number. Please record the number here: _______

This Form: Otherwise, please complete all parts of this paper form

	Health Card Number		Version Code	CHEO MRN (if known)
	___ ___ ___ ___ ___ ___ ___ ___ ___ ___		___ ___	
	Address			Home Phone Number
	Apt # Street Address			( ) -
	City Province Postal Code			Preferred Language ☐ English ☐ French ☐ Other: ___________
	Family Doctor's Name	Office Location		Doctor's Phone Number
				( ) -
Child/Youth	Parent/Guardian Name			Type
	First Middle Last			Mother/Father/Guardian
	Parent/Guardian Phone Numbers			Parent/Guardian Email
	Cell ( ) - Work/Alternate ( ) -			
Adult	Maiden or Alternate Name for Childhood Record at CHEO			Cell/Alternate Phone Number
	First Middle Last			( ) -
Risk Factors	Symptoms of COVID-19?	High Risk Contact?		COVID-19 Vaccination Status
	☐ No Symptoms ☐ Symptoms starting: M M / D D ☐ Fever ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Runny nose ☐ Congestion ☐ Headache ☐ Sneezing ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Diff swallowing ☐ Fatigue ☐ Muscle aches ☐ Taste/Smell change ☐ Abdominal Pain ☐ Other : _________________________	☐ No high-risk contacts with a COVID-19 positive person ☐ Recent contact with a COVID-19 positive person (within 10 days)		☐ Fully immunized, all doses more than 14 days ago ☐ Not immunized, partially immunized, or less than 14 days since final dose
		International travel last 14 days?		School Affiliation?
		☐ No ☐ Yes From: _____________________ Return date: M M / D D		☐ Staff (S) ☐ Student/Pupil (P) ☐ Family Member (F) ☐ Transportation (T)
Sample	Collection Date and Time	School Name and EDU Code		
	Date of Collection: M M / D D Time of Collection: H H : M M			

Fold and place this form in the outer pocket