DIN FYNSKE SYGEPLEJERSKE

JOURNAL

By my signature, I acknowledge that I have read, understand, and agreed to the terms and condition of this test, important information and to the fact that this document might be kept for up to 10 years and shared with third parties for historical, statistical or scientific purposes only.

Name: ____

Danish SSN number (Yellow card): ______________________________

Current address :____

____

Nationality: ____

Tlf number: ____

Working for Company: ____________________________________

Date and signature : ______________________________________

- Important Information -

Antibody testing determines whether you had COVID-19 in the past and now have antibodies against the virus. Antigentest determines if you currently have the Covid-19.

We only test adult persons > 12 years. Between 12 and 15 documents has to be signed by parents or guardian.

We can´t test you if you over the last 14d days have had any of these symptoms: cold-like symptoms, stuffy or runny nose, sneezing, sore throat, cough, fever, sudden loss of smell or taste.

This test can only identify virus at the earliest 48 hours after exposure.

By signing you accept that we contact the Danish Health Department if you have a positive covid-19 test and inform them about the result.

Have you had any symptoms within the last 14 days? NO __________ YES __________

Have you ever been tested positive for Covid-19? NO __________ YES __________

Result of Covid-19 antigentest + antibodytest (Filled out by nurse)

Time and date: ____________________________

ANTIGEN TEST: NEG: ________ POS ________

ANTIBODYTEST: NEG: ________ IgM pos _______ IgG pos __________