

School Staff/Student COVID-19 Test Process

The Florida Department of Health in Sarasota in partnership with Sarasota County Schools is offering PCR testing for **symptomatic** staff or students. This testing will be available by appointment only. The PCR test will consist of an oral swab collected by a DOH Sarasota Nurse. Specimens will be sent to the Health Department Laboratory for processing, with results being returned in approximately 48 hours.

To be eligible for testing, the individual must be a **symptomatic** student or staff member of Sarasota County. If a **symptomatic** family member needs to be tested to determine a staff or student's quarantine, they may be tested as well.

Symptoms may include any (or all) of the following:

•	Fever	•	Fatigue	•	GI Issues	•	Sweats
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To request a test, Sarasota County School staff or student's parent/guardian must complete the included COVID-19 Test Request form and email it to dohsrqcovid19@flhealth.gov. DOH staff will return call and provide appointment time and location. If you are unable to send the request form, please call 941-861-2941. When leaving a voicemail, please include your name and a return phone number. Please remember to STAY home until test results are available.

DOH Sarasota Testing Locations

DOH Sarasota	School Board Materials	Sarasota County Schools		
2200 Ringling Blvd.	Management	Transportation and Facilities		
Sarasota, FL 34237	101 Old Venice Road	2080 Citizens Parkway		
Monday - Friday	Osprey, FL 34429	North Port, FL 34288		
Hours: 11 a.m. – 1 p.m.	Monday - Friday	Monday - Friday		
	Hours: 9 a.m. – 1 p.m.	Hours: 9 a.m. – 1 p.m.		

Other testing locations are available if times or locations above are not convenient

Staff/Student Primary Care	Robert L. Taylor	FDEM COVID-19 Test Site		
Provider	Community Center	100 Cattleman Road		
	1845 34 th Street	Sarasota FL 34232		
	Sarasota, FL 34234			
	Open Daily from	Open Daily from		
	9 a.m. – 5 p.m.*	9 a.m. – 5 p.m.*		

^{*}May close during inclement weather



COVID-19 Test Request Form

Patient Information

Last Name:	First N	lame:		√I :		
DOB (MM/DD/YYYY):	P	atient Phone N	lumber:			
Gender: □ Male □ Female	Race:		Ethnicity:			
Home Street Address:						
City:	State:	Zip	Code:			
Parent/Guardian Name (if applicable)	:					
School:	Work Lo	cation:				
Symptoms Onset Date:						
Pregnant (Circle One): Yes	No					
Have you been tested before (Circle One): Yes No If yes, provide date:						
Healthcare Worker (Circle One):	Yes	No				
Current symptoms (check all that apply)						
☐ Fever ☐ Cough ☐ Sore thro	oat 🗆 Fatigu	e □ Shortn	ess of breath	☐ Congestion		
☐ GI Issues ☐ Headaches ☐ Bo	dy Aches	Sweats	Loss of Taste/Sn	nell Chills		