Visitor COVID-19 Health Disclosure & Waiver

Visitor Information

Full Name

Contact Number

Email Address

Date of Visit

Health Screening (Please check any that apply)

☐ I am currently experiencing symptoms such as fever, cough, shortness of breath, sore throat, or other respiratory illness.

☐ In the past 14 days, I have been in close contact with anyone diagnosed with COVID-19 or awaiting test results.

☐ In the past 14 days, I have traveled outside my local area or to a COVID-19 high-risk area.

Disclosure & Waiver

I certify that the information provided above is true and complete to the best of my knowledge. I understand that by entering this facility, I may be at risk of exposure to COVID-19 and I hereby release and hold harmless the organization from any liability relating to my visit. I agree to comply with all safety and health protocols while on the premises.

☐ I have read and agree to the terms listed above.

Visitor Signature

Date