COVID-19

# Health Questionnaire & WAIVER

Name: _____ Phone: _____

**Do you have ANY of the following symptoms?**

- ☐ Fever
- ☐ Dry Cough
- ☐ Body Aches
- ☐ Headaches
- ☐ Sore Throat
- ☐ Runny Nose
- ☐ Tiredness
- ☐ Shortness of Breath
- ☐ None of the Above

**Have you been in contact with anyone who has a confirmed case of COVID-19 in the past 14 days?**

☐ Yes ☐ No

**If you're a healthcare provider and the answer is YES, was this exposure without proper personal protective equipment (PPE)?**

☐ Yes ☐ No ☐ Not Applicable

**Have you been out of the country in the past 14 days?**

☐ Yes ☐ No

---

## RELEASE OF LIABILITY WAIVER

*I hereby agree that _____ has a proper sanitation and disinfection plan in place and is not responsible for any accidental transmission of COVID-19 that could occur by being in their business or within close proximity of each other.*

*I also agree that if I become symptomatic within 14 days of my visit, I will notify the business immediately.*

Signature: _____ Date: _____