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COVID-19 Information and Liability Waiver REQUIRED

1. **Have you had a fever of 100 degrees or above in the last 24 hours? No___ Yes___**

2. **Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, nausea, headache, cough, diarrhea, or shortness of breath? No___ Yes___**

3. **Have you had any loss of smell or taste within the last 14 days? No___ Yes___**

4. **Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus- type symptoms? No___ Yes___**

5. **Within the last 14 days, have you been on a plane or traveled outside of the New York City/North Jersey area? No___ Yes___**

6. **In the last 14 days, have you attended any gathering over 25 people? No___ Yes___**

7. **Has ANYONE in your family or living in your home or at work had COVID-19 or are presenting any symptoms now or within the past 14 days consistent with COVID-19? No___ Yes___**

8. **What is your purpose of this test: travel, work or personal reference _____**

CONSENT FOR TESTING

I understand that, because of the extended period of time of disease transmission, there may be an elevated risk of disease, including COVID-19 in the period immediately before or after potential exposure. By signing this form, I certify that my answers are true. By signing this form I acknowledge that I am aware of the risks involved from receiving testing at this time and I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business and employer from any claims related thereto. I give my consent to receive a COVID PCR (polymerase chain reaction) Nasal Swab from this medical professional and/or place of business. I hold harmless the practitioner for any test results that are given at the time of the testing as the transmission timeline is unpredictable and test results can change.

Print name: _____ Date of Birth:_____

Signature: _____ Date: _____