COVID – 19 Intake Screening Waiver

Name: _____

Date: _____ My Temperature today is: _____

Do you have a concern for a potential COVID-19 infection? Yes / No

Have you been tested for COVID-19? Yes / No

Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19? Yes / No

Have you or anyone you know traveled outside of the Province in the past 14 days? Yes / No

Do you have close contact with anyone with an acute respiratory illness? Yes / No

Do you have any of the following symptoms?

- □ Fever
- □ Shortness of breath
- □ Sore throat
- □ Chills
- □ Nausea/vomiting
- □ Abdominal pain
- □ New onset of cough/worsening cough
- □ Difficulty breathing
- □ Difficulty swallowing
- □ Headaches
- □ Diarrhea
- □ Pink eye (conjunctivitis)

- □ Decrease or loss of sense of taste or smell
- □ Runny nose/nasal congestion without other known cause
- □ Unexplained fatigue/malaise/muscle aches

If you are 70 years of age or older, are you experiencing any of the following symptoms:

- □ Delirium
- □ Unexplained or increased number of falls
- □ Acute functional decline
- □ Worsening of chronic conditions

Please review the above information to ensure it is correct before signing.

I, _____ (client's name) by receiving Reiki from _____ (Practitioners name) under any circumstances abide and waive my legal or otherwise rights to make any claims or actions now or in the future against _____ (Company Name) performed by _____ (Practitioners name) should I contract COVID-19 now or in the future.

X _____

client signature