Temperature - Taken by staff

Visitor Health Screening Questionnaire/Waiver COVID-19 6/20/20

In order to promote safety and well-being for our staff and patients, we have implemented Health and Safety requirements for people entering our office. By signing below, you have agreed to have your temperature taken, to answer the following questions, to wear a face mask, and to comply with all reasonable safety requests. Refusal to do so, or if your temperature is above 100 degrees F, will require you to leave our office and reschedule your appointment if needed. By signing this document, you further agree to waive any legal claims and remedies you may have against any occupant of these premises based on illness or potential exposure to COVID-19. If you do not agree with the terms of this document or our published Health and Safety Policy, please leave immediately.

Do you have any of the following symptoms?	YES	NO
Fever (over 100 degrees F) or felt feverish		
Cough		
Shortness of breath or difficulty breathing		
Fatigue or weakness		
New loss of taste or smell		
Sore throat		
Headache		
Chills		

	YES	NO
Have you been diagnosed with COVID-19 in the last 14 days?		
In the past 14 days have you been in contact with someone who is ill with a respiratory illness, who is under investigation for COVID-19 or who has a confirmed diagnosis of COVID-19?		

Please sign and date below to confirm your answers to the above questions and your agreement to abide by our posted OSSMSA Health and Safety Policy.

Signature _____

Printed Name_____ Date _____