

COVID 19 MEMBER SCREENING AND WAIVER

Full Name	Email Address	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	City	Province/Region
<input type="text"/>	<input type="text"/>	<input type="text"/>
Country	Date of Birth	Zipcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

Covid-19 Client Screening.

[Redacted]

[Redacted]

- Fever over 100.4

Initial here:

- Shortness of breath

Initial here:

- Coughing

Initial here:

- Loss of smell

Initial here:

- Loss of taste

Initial here:

[Redacted]

Initial here:

[Redacted]

Initial here:

[Redacted]

[Redacted]

Initial here:

[Redacted]

Initial here:

[Redacted]

Initial here:

[Redacted]

Initial here:

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☐ I agree to use electronic records and signatures