ChesX COVID-19 Waiver

Name_____
Dates attending Chesapeake Experience programs_____
Which Programs?_____

In Case of Emergency Contact Information:
Name_____
Relationship_____ Number_____

Question	Yes	No
Do you have a fever or chills?		
Do you have a cough?		
Do you have shortness of breath or any difficulty breathing?		
Do you have any muscle pain?		
Do you have a headache?		
Do you have a sore throat?		
Do you have any other flu-like symptoms?		
Do you have any recent loss of taste or smell?		
Have you experienced any recent upset stomach or diarrhea?		
Do you have any of the following?: Heart disease Lung disease Kidney disease Diabetes Autoimmune Disorders		
Are you over 65?		

Are you in contact with anyone who has been confirmed to be COVID-19 positive or suspected in the past 14 days? Yes___ No___

Have you been tested for COVID-19, if so when and what was the result?_____

Have you been diagnosed with COVID-19, if so when?_____

Name of Recorder _____

ChesX COVID 19 log:

Name_____
Dates attending Chesapeake Experience programs_____
Which Programs?_____

In Case of Emergency Contact Information:
Name_____
Relationship_____ Number_____

Date	Time	Temperature	Changes to Wavier	Recorder