FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of the North
Consent COVID-19

TO BEST PROTECT YOUR HEALTH AND THE HEALTH OF OTHERS, PLEASE FILL OUT THIS FORM BEFORE EACH SESSION.

☐ **YES** ☐ **NO** Have you traveled inside or outside the US in the last 14 days?

☐ **YES** ☐ **NO** If so, did you practice all safe practices (social distancing, wearing a mask when in an enclosed space, and handwashing protocols?)

☐ **YES** ☐ **NO** Have you or anyone in your household been tested and/or diagnosed with COVID-19 within the last 14 days?

☐ **YES** ☐ **NO** Have you attended any large gatherings without practicing social distancing or wearing a mask?

☐ **YES** ☐ **NO** Do you have any new discomfort with exertion or exercise?

Please tell your provider if you are experiencing any of the following now or as a NEW PATTERN since the beginning of the pandemic:

- Fever
- Chills
- Cough
- Sore throat
- Diarrhea, digestive upset
- Nasal, sinus congestion
- Loss of sense of taste or smell
- Fatigue
- Shortness of breath
- Sudden onset of muscle soreness (not related to a specific activity)
- Rash or skin lesions (especially on the feet)

- I declare that the information provided above is true and accurate to the best of my knowledge. If I develop any of the symptoms outlined above, I agree to contact the YMCA of the North to let them know. I further agree to let the YMCA of the North know if I am tested and receive a positive diagnosis within 14 days of receiving treatment.
- I acknowledge that I am voluntarily entering the premises of the site for purposes of patronizing space for my personal benefit and the value of such benefit is sufficient consideration for my voluntary execution of this agreement.
- I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive services from my practitioner.
- I understand that my name and contact information might be shared with the state of health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.
- I agree that throughout my course of treatment, I will refrain from attending sessions if I am experiencing any of the symptoms of COVID-19 listed above or have been exposed to COVID-19.

NOTE: At this time, we ask that you wear a mask during your treatment unless you are receiving services on your face. If you experience any symptoms of illness during your session, please inform you practitioner and discontinue your treatment.

Print Name: _____ Date: _____

Signature: _____