Ultimate Health Clinic
Your pathway to better health

COVID-19 PRE-SCREENING

By attending my appointment...

I agree that I am **not** currently experiencing any of the following symptoms:

- Fever and/or chills
- New onset of cough or worsening chronic cough
- Shortness of breath or difficulty breathing
- Decrease or loss of sense of taste or smell
- If adult >18 years of age: unexplained fatigue/lethargy/malaise/muscle aches
- If child <18 years of age: nausea/vomiting, diarrhea

I agree that I, **regardless of vaccination status**, have not:

- Tested positive for COVID-19 in the past 10 days
- Been told to self-isolate
- Knowingly been exposed to someone with COVID-19

If **not immunized or only partially immunized**, I agree that I have not:

- Travelled outside of Canada in the past 14 days
- Been in close contact with a confirmed case of COVID-19 without wearing appropriate PPE

If you have experienced any of the above, please reschedule your appointment at least 10 days from now.

BY SIGNING BELOW, I AGREE THAT I HAVE NOT EXPERIENCED ANY OF THE ABOVE. I ALSO AGREE THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS ACCURATE AND TRUE.

Client Signature : _____ Date : _____

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