Ahlara International

Name:_____

Street Address:_____

City/State/Zip:_____

Phone: _____Email:_____

COVID - 19 Liability Release Waiver

****Signature Required Prior to Every Scheduled Appointment to Best Protect Your Health and the Health of Others.**

Have you been tested for COVID-19? If yes, what type of test did you have? _____

When was your test? _____

What were the results?_____

Symptoms of COVID-19 include:

◎ Fever ◎ Fatigue ◎ Dry Cough ◎ Sore Throat ◎ Difficulty Breathing

I agree to the following:

I understand the above symptoms and affirm that I, as well as household members, do not currently have, nor have experienced the symptoms listed above WITHIN THE LAST 14 DAYS.

I understand that my name and contact information might be shared with the state 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.

By my signature below I acknowledge that I am voluntarily seeking treatment/therapy/services from Ahlara International knowing that there may be some risk of infection even though Ahlara International is following best practices and hereby waive and release Ahlara International from any and all liability from subsequent illness occurring at any time after my treatment/therapy/services.

Signature:_____ Date: _____