ACUPUNCTURE & INTEGRATIVE MEDICINE COLLEGE, BERKELEY

FORM: COVID-19 SELF-SCREENING & CONSENT TO BE ON CAMPUS

SELF-SCREENING

I declare that **in the last 14 days**:

- I have not been in close contact with someone who is:
  - ➔ Symptomatic but unable to get tested for COVID19
  - ➔ Diagnosed with COVID19 and not yet cleared
  - ➔ Waiting for test results for COVID19
- I have **not experienced a fever (100.4°F/38°C) or chills**
- I DO **NOT** HAVE A **NEW** EXPERIENCE of any of the following symptoms:
  - ➔ Cough
  - ➔ Sore throat
  - ➔ Difficulty breathing or chest tightness
  - ➔ Loss of taste or smell
  - ➔ Nasal congestion
  - ➔ Diarrhea
  - ➔ Nausea
  - ➔ Fatigue
  - ➔ Headaches
  - ➔ Muscle or body pain (unrelated to exercise)

IF ANY OF THE ABOVE SYMPTOMS ARE A CHRONIC EXPERIENCE DUE TO A CHRONIC CONDITION, I will notify the Clinic Director and I agree to **provide the school with the results of a COVID19 test taken a week before** I enter to campus during the each academic term. (Patients need to notify the Front Desk.) I understand that at any point I may be required to take another test in order to return, if my care team requires, if the school experiences an outbreak, or if public health regulations change.

CONSENT TO BE ON CAMPUS

By signing this form:

- I confirm that I voluntarily enter the premises of the Acupuncture and Integrative Medicine College in Berkeley (AIMC). I acknowledge that, despite the implementation of preventative measures intended to minimize exposure to and transmission of COVID-19, ***I am increasing my risk of exposure to the novel coronavirus, COVID-19.***
- I understand that many **chronic conditions** can make a person vulnerable to **a severe and life-threatening experience** of COVID19, and that even people **without chronic conditions and who had mild COVID19 symptoms** can experience **long-lasting negative effects** of a COVID19 infection. I understand this and by willingly entering the AIMC facility, *I know I increase my risk of exposure to COVID-19*.
- I agree to comply with all AIMC safety protocols and procedures to reduce the spread of COVID-19 at the AIMC facility.
- ***If I experience any of the above symptoms associated with COVID19, I will immediately notify the AIMC Clinic Director (clinicdirector@aimc.edu) and consent to providing information about my symptoms and exposure. This information will remain confidential and is only for the purposes of contact tracing and preventing further spread of the novel coronavirus.***

Signature: ______________________________ Date: ________________

Name (Print) ______________________

Updated Draft December 31, 2020