Coronavirus Self Declaration Form

For the health and safety of our community, declaration of illness is required. Be sure that the information you provide is accurate and complete. Please get immediate medical attention if you have any of the COVID-19 signs and symptoms.

Name *

First Name Last Name

ID Number *

Contact Number *

Email Address *

Have you travelled abroad during 2020? *

- (●) Yes
- ( ) No

Name of the area(s) and date(s) visited in last 21 days *

Country, State, City

Have you been in contact with people being infected, suspected or diagnosed with COVID-19? *

- [x] Yes
- [ ] No

If yes, Please state your relationship with the people (close or casual contact) and your last contact date with them *

Please state whether you've experienced/are experiencing the following

	Yes	No
Fever	○	○
Cough	○	○
Shortness of Breath	○	○
Persistent Pain in the Chest	○	○
Body Pains	○	○
Runny Nose	○	○
Loss of Sense of Smell	○	○
Loss of Appetite	○	○
Vomitting	○	○
Diarrhoea	○	○
Nausea	○	○
Sore Throat	○	○

I hereby certify, represent, and warrant as follows: Within the twenty-one (21) days immediately preceding the Date of this Health Declaration Form ("Declaration"), I HAVE NOT been tested for COVID-19 or related illness (caronavirus). *

- [ ] Yes
- [ ] No

I HAVE NOT tested positive for COVID-19 or related illness (caronavirus). *

- ◯ Yes
- ◯ No

I HAVE NOT been in direct contact with or in the immediate vicinity of any person I knew and/or now know to be carrying the Coronavirus or has been identified as a potential carrier of the Coronavirus. *

- ◯ Yes
- ◯ No

I HAVE NOT been in any location positively designated as hazardous and/or potentially infected with the Coronavirus by a recognized health or regulatory authority, such as countries deemed high risk for Coronavirus as per the President's declaration in terms of the National Disaster *

- ◯ Yes
- ◯ No

I AGREE to notify the Psychologist of any change in status, including diagnosis with Coronavirus and/or quarantine, within thirty (30) days either before or following this and future appointments. *

- ◯ Yes
- ◯ No

I AGREE to wear a mask or face shield at all times while receiving treatment and will take all reasonable precautionary steps that may be recommended/required by the Psychologist. *

- ◯ Yes
- ◯ No

I consent to having my temperature taken and recorded by any representative of the practice prior, during, and/or after any treatment, and will provide any follow up information reasonably requested by the Psychologist. *

- ◯ Yes
- ◯ No

Due to the nature of the CORONA virus I ACKNOWLEDGE and ACCEPT the potential risk of exposure to the virus during my consultation with the Psychologist at this facility, even with all possible risk being mitigated by the practice through precautions being taken as described by government recommendations being put in place. *

- ◯ Yes
- ◯ No

I ACKNOWLEDGE and ACCEPT that this Declaration shall be governed by the laws of South Africa. I irrevocably agree that the Courts of South Africa shall have jurisdiction to hear and determine

any suit, action or proceeding, and to settle any dispute which may arise out of, under, or in connection with this Declaration and for such purposes hereby irrevocably submit to the jurisdiction of such Courts. Nothing contained herein shall limit the right of CHERILEE BOTHA COUNSELLING PSYCHOLOGIST to take proceedings in any Court. *

- ◯ Yes
- ◯ No

I ACKNOWLEDGE and ACCEPT that this Declaration will be considered as my consent to CHERILEE BOTHA COUNSELLING PSYCHOLOGIST to disclose, share, record and store this Declaration with any relevant authority or service provider for the purposes of ensuring the safety and security of any and all third parties that may come in contact with me prior, during, and after my consultation(s). *

- ◯ Yes
- ◯ No

If over the previous twenty one (21) days prior to the treatment, I have visited any of the countries deemed as high risk for the Coronavirus as per the President's declaration in terms of the National Disaster, I AGREE to provide a written verification executed by a certified physician or a medical facility prior to treatment that (i) a CDC-approved Corona virus test was administered on me and was negative or (ii) I do not meet the CDC criteria for administering a Coronavirus test and do not exhibit any Coronavirus symptoms. *

- ◯ Yes
- ◯ No

I AFFIRM that all the above statements apply equally to the persons and/or minors under the age of 12 accompanying me (either with me or with my consent) to this appointment: *

- ◯ Yes
- ◯ No

I acknowledge that the information I've given is accurate and complete.

In signing below, I, an individual over the age of 12 of sound mind, knowingly, voluntarily, and freely agree to the terms of this binding Declaration, and in doing so represent the truthfulness and veracity of the above answers.

Date

Month Day Year