

Capital Health

COVID-19 Waiver - Visitor
English Version / Spanish on Reverse

I, _____, understand that the novel coronavirus, COVID-19, is extremely contagious and is believed to spread by person-to-person contact. I understand that during the time that I spend at Capital Health, I may come in contact with individuals infected with COVID-19, including patients, visitors and staff, and that I could get the disease. I recognize that there is currently no vaccine for COVID-19, and no treatment that cures COVID-19.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through my presence at Capital Health and I agree to hold harmless Capital Health, its physicians, and all members of its staff from any liability resulting from any exposure I may have to COVID-19 as a result.

Print Name of Visitor/Authorized Representative

Signature of Visitor/Authorized Representative

Date

Time

Qualified Interpreter Identification (if applicable)

Date

Time

Capital Health

Exención por COVID-19 - Visitas *Spanish Version/ English on Reverse*

Yo, _____, comprendo que el nuevo coronavirus, COVID-19, es extremadamente contagioso y se cree que se transmite por contacto de persona a persona. Entiendo que durante el tiempo que estoy en Capital Health, puedo entrar en contacto con personas infectadas con COVID-19, incluidos pacientes, visitas y personal, y que podría contraer la enfermedad. Reconozco que actualmente no existe una vacuna para COVID-19, ni ningún tratamiento que lo cure.

Por la presente, reconozco y asumo el riesgo de contagiarme con COVID-19 por mi presencia en Capital Health y acepto eximir de toda responsabilidad a Capital Health, a sus médicos y a todos los miembros del personal como consecuencia de la exposición que pueda tener al COVID -19.

Nombre en letra de molde de la visita/del representante autorizado

Firma de la visita/del representante autorizado

Fecha

Hora

Identificación del intérprete calificado (si corresponde)

Fecha

Hora