



## COVID-19 Agreement

To protect our students and staff, I agree to remain home if I have:

- Fever (a temperature of 100° or more)
- Cough
- Sore throat
- Chills
- Muscle pain
- Headache
- New loss of taste or smell
- Nausea/Vomiting/Diarrhea
- Congestion/Runny Nose

If I have any of these signs of COVID-19, I will not return to Philly Art Center until:

- I have tested negative for COVID and is otherwise well enough to return to class
- **OR**
- I have seen a healthcare provider who has documented a reason for the symptoms other than COVID
- **OR**
- All are true: 1) at least 10 days since the start of symptoms AND 2) fever free off anti-fever medicines for 3 days AND 3) symptoms are getting better.

If I am diagnosed with COVID-19, I will not return to Philly Art Center until the following:

- It has been at least 10 days since I first had symptoms
- **AND**
- I have no fever off anti-fever medicines (ex: Tylenol, Ibuprofen) for 3 days **AND**
- My symptoms are getting better

If anyone in my household is exposed, suspected or diagnosed with COVID-19 I will not return to PAC and will contact them to devise a return plan. If anyone in my household develops new cough, shortness of breath or has a 100° fever or higher, or any of the TWO symptoms above, I will get that person tested for COVID-19 or seek alternate diagnosis from primary physician. Upon notice or observation of any of these scenarios, I will contact PAC immediately to set up a return strategy that aligns with all safety protocol. [info@phillyartcenter.com](mailto:info@phillyartcenter.com).

Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Release for Communicable Diseases Including COVID-19

**Directions: A completed waiver must be received to attend class.** Forms are valid for one year, after which a new waiver is required. Please email to [info@phillyartcenter.com](mailto:info@phillyartcenter.com) ahead of your program start date for all locations.

First and Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### ASSUMPTION OF RISK/WAIVER OF LIABILITY/INDEMNIFICATION AGREEMENT

In consideration of being allowed to participate in PAC programming, I, hereby acknowledge and agree that:

Participation includes possible exposure to and illness from infectious diseases including but not limited to influenza and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and

I authorize Philly Art Center, Art Mark LLC, and its authorized representatives, to take whatever actions it may consider warranted under the circumstances regarding my health and safety; and

I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe any unusual or significant hazard during my participation, I will not participate and bring such to the attention of PAC's director immediately; and

I, for myself and all of my heirs, assigns, and personal representatives, **hereby release and hold harmless** Philly Art Center, Art Mark LLC, its director, teachers and all employees and authorized representatives, ("Releasees"), with respect to any and all illness, disability, death or damage to any persons that may occur, whether arising from the negligence of Releasees or otherwise, either directly or indirectly, as a result of my participation in PAC programming; and

**I knowingly and freely assume all such risks of exposure to infectious diseases**, both known and unknown, even if arising from the negligence of the Releasees or others, and assume full responsibility for my participation.

**This will certify that I have read this release of liability and assumption of risk, fully understand its terms and that I have given up substantial rights by signing it. I do consent and agree to our release provided above for all of the Releasees and agree to indemnify and hold harmless the Releasees for any and all liabilities arising from my presence or participation, to the fullest extent provided by law.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



# COVID-19 Screening Tool

Date: \_\_\_\_\_

Name: \_\_\_\_\_

1. **TEMPERATURE:** \_\_\_\_\_ °F     Temperature taken on-site     Temperature taken at home

**If temperature 100°F or higher → Please DO NOT ATTEND**

## 2. SYMPTOMS

Do you have any of the following?

Cough     Shortness of breath

**If YES to either → Please DO NOT ATTEND**

**NONE**

**OR**

Chills     Sore throat

**If YES to 2 or more → Please DO NOT ATTEND**

Nausea/Vomiting/Diarrhea     Muscle pain

Headache     New loss of taste or smell     Congestion/Runny Nose

**NONE**

## 3. EXPOSURE

Have you been exposed to anyone with a confirmed case of COVID-19 in the past 14 days?

YES     NO

**If YES → Please DO NOT ATTEND**

Comments:

Signature: \_\_\_\_\_