



GREEN MOUNTAIN TRIBE INC.

COMPANY REGISTRATION NO. CN201212508
3356 Harvard St., Brgy. Pinagkaisahan, Makati City
Cel No. +639 499598834

WAIVER FORM

Date: _____

Activity: _____

NAME: _____

ADDRESS: _____

TEL. NO.: _____

MOBILE NO.: _____

BLOOD TYPE: _____

AGE: _____

I, _____, of legal age, do hereby join
Green Mountain Tribe Inc. (GMT) on the said event. I have understood the fact that this activity has
dangerous and risky conditions thus, I agree that the club and the organizers of the event shall not be
held liable for any untoward incidents that may occur during the event

This is also to certify that all information I have given here are true and correct.

SIGNATURE OVER PRINTED NAME, DATE SIGNED

Contact person in case of emergency:

NAME: _____

ADDRESS: _____

TEL. NO.: _____

MOBILE NO.: _____

RELATIONSHIP TO CLIMBER: _____ BLOOD TYPE: _____



GREEN MOUNTAIN TRIBE INC.

COVID-19 SCREENING ASSESSMENT FORM

IN COMPLIANCE WITH IATF PROTOCOL, THE TEAM WOULD LIKE TO ASSESS THE FOLLOWING COMMON SYMPTOMS OF COVID-19 AND EXPOSURE. PLEASE ANSWER TRUTHFULLY.

ALL ASSESSMENT WILL BE KEPT CONFIDENTIAL.

GENERAL INFORMATION

| NAME | | | | |
|---|--------------------------|------------------------|----------------------|----------------------|
| FIRST NAME | MIDDLE NAME | LAST NAME | NICKNAME | EXT. NAME |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| ADDRESS | | | | |
| STREET NO. | STREET ADDRESS/BARANGGAY | CITY/TOWN/MINICIPALITY | ZIP CODE | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| CONTACT PHONE NUMBER | | MOBILE PHONE NUMBER | EMAIL ADDRESS | |
| <input type="text"/> | | <input type="text"/> | <input type="text"/> | |
| SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | EMAIL ADDRESS | | <input type="text"/> | |

GENERAL ASSESSMENT

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **FEVER**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **COUGH**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **SHORTNESS OF BREATH**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **CHILLS**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **SORE THROAT**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **MUSCLE ACHE**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **LOSS OF TASTE OR SMELL**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OR WORSENING OF **SEVERE HEADACHE**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OR WORSENING OF **RUNNY NOSE OR NASAL CONGESTION**?

☐ YES ☐ NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OR WORSENING OF **NAUSEA, VOMITTING, DIARRHEA** THAT'S NOT RELATED TO CHRONIC OR SEASONAL ILLNESS?

☐ YES ☐ NO

GENERAL ASSESSMENT

HAVE YOU HAD A CLOSE CONTACT WITH ANYONE WHO HAD COVID-19?

CLOSE CONTACT IS DEFINED AS LESS THAN 6FT IN MORE THAN 10 MINUTES

☐ YES ☐ NO

HAVE YOU HAD DIRECT CONTACT WITH FLUIDS TO ANYONE YOU KNOW WHO HAD COVID-19 WITH OR WITHOUT WEARING MASK?

FOR EXAMPLE BEING COUGHED OR SNEEZED TO

☐ YES ☐ NO

DID YOU TRAVEL OUTSIDE THE COUNTRY WITHIN THE PAST 14 DAYS?

☐ YES ☐ NO

HAVE YOU'VE BEEN DIAGNOSED WITH COVID-19 AND NOT YET CLEARED TO DISCONTINUE ISOLATION?

☐ YES ☐ NO

HAVE YOU HAD COVID-19 TEST (SWAB/RAPID) AND IS AWAITING RESULT WITHIN 10 DAYS?

☐ YES ☐ NO

WITHIN 14 DAYS, HAS A PUBLIC HEALTH OR MEDICAL PROFESSIONAL TOLD YOU TO SELF-MONITOR, SELF-ISOLATE, OR SELF-QUARANTINE BECAUSE OF THE CONCERNS OF COVID-19?

☐ YES ☐ NO

ARE YOU WORKING IN A COVID-19 FACILITY?

☐ YES ☐ NO

ATTESTATION

LIST OF PLACES OUTSIDE METRO MANILA YOU'VE BEEN TO IN THE LAST 14 DAYS:

ANSWER N/A IF NONE

LIST OF PLACES ABROAD YOU'VE BEEN IN THE PAST 14 DAYS:

ANSWER N/A IF NONE

WHAT IS YOUR CURRENT BODY TEMPERATURE?

I HEREBY DECLARE THE QUESTION WERE ANSWERED TRUTHFULLY.
WRITE YES IF YOU'VE ANSWERED TRUTHFULLY, FOLLOWED BY YOUR SURNAME AND THEN YOUR FIRST NAME.
(E.G. YES DELACRUZ JUAN)

SIGNATURE AND DATE

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