



VIRGINIA  
HOLOCAUST  
MUSEUM

## **Welcome back to the VHM!**

I understand COVID-19 is highly contagious, that the disease can cause serious injury and even death, and that entering museums like the VHM, where people congregate, increases my risk of infection.

\_\_\_\_\_ (INITIAL HERE) I understand that the VHM will undertake reasonable measures to minimize the spread of COVID-19, but I will not hold the VHM responsible should I contract COVID-19. I also understand that in the event I do contract COVID-19, neither I nor the VHM will be able to ascertain where or how I contracted it.

I understand that I must sanitize my hands before entering the VHM and that I must wear a mask that covers my mouth and nose while at the VHM unless removal of the mask is expressly permitted by the VHM. If I cannot comfortably or safely wear a mask at the VHM, I will leave the VHM premises.

I will follow the written and oral instructions of the VHM concerning COVID-19 safety and I understand my failure to follow such instructions may be grounds for my removal from VHM premises.

I confirm that I have not tested positive for the novel coronavirus or, if I have previously tested positive for the novel coronavirus, I have since been tested and advised by a physician that I am no longer positive for that infection and I am no longer a risk of infecting others with the novel coronavirus or COVID-19.

I confirm that I am not waiting for the results of a laboratory test for COVID-19.

I verify that I have not returned to Richmond from any country outside of the United States whether by car, air, bus, or train in the past 14 days and that I will not enter the VHM within 14 days of such travel.

I verify that I have not been identified as someone who has been in contact with someone who has tested positive for the novel coronavirus nor have I been asked to self-isolate by any health professional or any governmental agency and that I will not enter the VHM in the event I am so identified.

I confirm that I do not presently have any of the following symptoms of COVID-19 and that I will not enter the VHM in the event I am experiencing any of these symptoms:

- Fever > 100.3 F
- Sore Throat
- Difficulty Breathing
- Cough
- Shortness of Breath
- Flu-like Symptoms

I will immediately notify the VHM if I contract the virus within the two weeks following any visit to the VHM.

I verify the information I have provided on this form is truthful and accurate.

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

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

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