Proof of Vaccine			
Participant Name	Proof Seen (Yes)	Verified by:	Verification date:

Proof of Medical Exemption				
Participant Name	Proof Seen (Yes)	Duration of Exemption:	Verified by:	Verification date:

Proof of Negative Test						
Participant Name	Proof Seen (Yes)	Type of Test:	Date of Test:	Time of test:	Verified by:	Verification date: