COVID-19 Informed Consent & Health Status

NAME: ____ **DATE:** ____________________

EMAIL: ____________________________ **PHONE:** ______________________________

I understand that close contact with people increases the risk of infection from Covid-19. I acknowledge that I am aware of the risks involved and give consent to receive massage. Initial_______

I understand that my name and contact information may be shared with the state health department if anyone at this facility tests positive for Covid-19. My relevant information will only be shared based on suspected exposure date, and only for appropriate follow up by the health department. Initial_______

Are you or any members of your household experiencing any of the following symptoms? Please check all that apply.

- ❏ congestion, cough
- ❏ diarrhea
- ❏ fever
- ❏ shortness of breath, wheezing
- ❏ sore throat
- ❏ sudden loss of taste and/or smell
- ❏ nausea or vomiting
- ❏ severe fatigue
- ❏ No one in my household is experiencing any of the symptoms listed.

Have you gathered with people outside of your household in the past 14 days without wearing masks?

- ❏ Yes
- ❏ No

Do you believe that you or a member of your household was exposed to COVID-19 in the past 14 days? *

- ❏ Yes
- ❏ No

Have you been tested for Covid-19 in the past 14 days

- ❏ Yes
- ❏ No

IF yes, what was the result? Positive Negative Awaiting Results

Have you been vaccinated for COVID-19?

- ❏ Yes, I have received one dose.
- ❏ Yes, I have received both doses.
- ❏ No, I have not been vaccinated for COVID-19.

The information provided here is true and accurate to the best of my knowledge.

Signature ___________________________________ ***Date***______________________