COVID-19 Informed Consent & Health Status

NAME: _____ **DATE:** _____

EMAIL: _____ **PHONE:** _____

Consent

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 a client or practitioner at this facility tests positive for Covid-19. My information will only be shared in the event that it is relevant based on suspected exposure date, and only for appropriate follow up by the health department. Initial_____

Current Health relative to Covid-19

Have you been tested for COVID-19? If yes, what type of test did you have?

When was your test?

What were the results?

Have you been in places with a high infection rate within the last two weeks (e.g., state- designated "hotspots")? If yes, please explain.

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

___ Fever
___ Chills
___ Cough
___ Sore Throat
___ Diarrhea, digestive upset
___ Nasal, sinus congestion
___ Loss of sense of taste or smell
___ Fatigue
___ Shortness of Breath
___ Sudden onset of muscle soreness (not related to specific activity)
___ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise?

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

Signature _____ ***Date***_____