COVID-19 Related Screening

NAME:
DATE:
TIME:
TEMPERATURE:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now,or have you recently had, any respiratory or flu symptoms, sore throat, or shortness
of breath? Yes ☐ No ☐
3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes ☐ No ☐
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has corona virus-type symptoms? Yes ☐ No ☐

Consent for Treatment I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____Date: _____

Parent or Guardian Signature (in case of a minor): _____Date: _____

Therapist Signature_____Date: _____

Therapist Temperature