COVID-19 Health Information and Liability Waiver

Client Name ____

COVID-19 Health Information

1. Have you experienced any cold or flu-like symptoms in the last 14 days (to include: fever, cough, difficulty breathing, sore throat, pressure in the chest, extreme fatigue, earache, persistent headache, diarrhea, and persistent loss of smell or taste)? Yes No
2. Have you received a confirmed diagnosis for COVID-19 by a COVID-19 test or from a healthcare professional in the past 14 days? Yes No
3. Have you had close contact or cared for someone diagnosed with COVID-19 or having coronavirus-type symptoms within the last 14 days? Yes No
4. Have you traveled by airplane within the last 14 days? 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, Lynda Kees massage therapy/In Touch, from any claims related thereto. I give my consent to receive treatment from this practitioner, Lynda Kees.

Client Signature ______________________________ Date _________________________