Covid-19 Spa services Consent

Name First:_____ Last:_____

Email: _____

Phone Number: _____

Date is Birth: _____

Street Address: _____Street Address Line #2_____

City: _____

State: _____Postal/ Zip _____

A weak immune system can put you at greater risk for contracting COVID-19.

Please select the ones that apply.

☐ Diabetes ☐ Asthma ☐ Cancer treatment ☐ Epilepsy ☐ Heart disease ☐ Hepatitis ☐ Thyroid disease ☐ High blood pressure ☐ Endocrine disorder ☐ Other

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Please disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

- Have you tested positive for COVID-19?

  ○ Yes ○ No
- Have you been tested for COVID-19 and are awaiting results?

  ○ Yes ○ No
- Have you been in contact with someone who has tested positive for COVID-19?

  ○ Yes ○ No

  Have
- you traveled abroad by air or cruise ship in the past 14 days?

  ○ Yes ○ No

Please select the signs or symptoms that you are currently experiencing or have experienced within the last 15 days.

☐ Fever or above normal temperature ☐ Shortness of breath ☐ Dry cough ☐ Runny nose ☐ Reduction in your sense of smell ☐ Sore throat

- Have you taken the vaccination? ___ Have you taken both doses? ___ If so which brand? _____

Further Comments: I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature _____

Date: _____