Health Information–COVID-19 Information & Liability Waiver

Client Name: _____

1. Have you had a fever or chills in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had any COVID type symptoms in the last 14 days: Yes ☐ No ☐

*respiratory or flu symptoms	*sore throat
*cough	*shortness of breath
*fatigue (sudden onset)	*muscle or body aches (new)
*headache	*nausea or vomiting
*loss of taste or smell	*diarrhea

3. Have you or any household member been in contact with anyone in the last 14 days Yes ☐ No ☐

who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

If yes so, please note the location_____

Consent for Treatment I understand that, because myofascial release and 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: _____

Front Desk Checklist

- ☐ Client Wearing a Face Mask or Provided
- ☐ Client Provided Hand Sanitizer or Washed Hands in Washroom
- ☐ Client Answers “No” to all 3 questions above _____
- ☐ Client Temperature reading is below 100°F Current Temperature: _____

Therapist Signature: _____ Date: _____