Health Information–COVID-19 Information & Liability Waiver

Client Name: ______________________________________ Date: __________________________

COVID-19 Information

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, cough, sore throat, or shortness of breath? **Yes** ☐ **No** ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?
   Some symptoms may include;
   - Fever
   - Headaches
   - Fatigue
   - Dry cough
   - Difficulty breathing
   - Chills
   - Nausea or vomiting
   - Diarrhea
   - New widespread muscle pain
   - Fatigue
   - Loss of taste & smell
   - Bruising, redness, swelling, or cramping in lower legs and feet
   - Red or purple toes
   - Confusion

   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 (for minor): __________________________Date: ____________