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, 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 coronavirus-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 treatments. I voluntarily agree to assume those risks, and I release and hold harmless the practitioner and business from any claims related thereto. I give my consent to receive treatment form this practitioner.

Client Signature: _____Date:_____

Practitioner Signature: _____ Date:_____