Health Information–COVID-19 Information & Liability Waiver

Cli	ent Name:	
Da	te:	
CC	OVID-19 Information	
1.	Have you had a fever in the last 24 hours of 100°F or above? Yes \square No \square	
2.	Do you now, or have you recently had, any respiratory or flu symptoms, sore breath? Yes \square No \square	throat, or shortness of
3.	Have you been in contact with anyone in the last 14 days who has been diagram coronavirus-type symptoms? Yes \Box No \Box	gnosed with COVID-19 or ha
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.		
Cli	ent Signature:	Date:
Ра	rent or Guardian Signature (in case of a minor):	Date: