COVID-19 Information & Liability Waiver

Client Name: _____ Date: _____

COVID-19 Information

1. Have you had a fever in the past 24 hours of 100.4°F or above? Yes ☐No ☐

2. Do you now or have you had any of the followings symptoms in the past 3 weeks? Fever of 100.4°F or more, cough, sore throat, shortness of breath, chills, headache, muscle pain, Diarrheas, digestive upset, rash or skin lesions or loss of taste or smell? Yes ☐No ☐

3. Have you been tested for COVID-19? If yes what type of test? Yes ☐No ☐

4. Have you been in contact with anyone in the last 30 days who has been diagnosed with COVID-19 or who has had coronavirus-type symptoms? Yes ☐No ☐

5. Have you or have you been in close contact with anyone who has traveled outside of the Joplin area in the past 30 days? 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.

I also understand that my name and contact information might be shared with the state health department in the event that a client or practitioner in this office tests positive for COVID-19. My Contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

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