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. 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 continued treatment, 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:_____

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