

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 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 (in case of a minor): _____ Date: _____

