**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 facials and 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: _____