COVID-19 Health Information & Informed Consent

Client Name: _____ Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read this form carefully and fill it out completely. Let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1. **Are you fully vaccinated against COVID-19? Yes ☐ No ☐**
   *If **yes**, please skip to the Consent for Treatment and Self-Attestation of Vaccination Status on the second page.*
   *If **no**, continue. Also, please be aware that you will have to wear a mask while here.*
2. Have you had a fever in the last 24 hours of 100.4°F or above? Yes ☐ No ☐
3. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐
4. Have you been in close contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐
5. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐

   If yes, location: _____
6. Have you been tested for COVID-19? Yes ☐ No ☐

   a. If yes, what type of test did you have? _____

   b. When was your test? _____ What were the results? _____
7. Have you been in places with a high infection rate within the last two weeks (e.g., state-designated "hotspots")? Yes ☐ No ☐ If yes, please explain. _____
8. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐
9. Do you have trouble exercising to get your heart rate and respiratory rate up? Yes ☐ No ☐
10. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐
11. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

Temperature (Taken upon arrival): _____

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Consent for Treatment and Self-Attestation of Vaccination Status

To proceed with receiving care, I understand and confirm the following (Initial in all places provided):

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented and **this practitioner is fully vaccinated**. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I understand that close contact with unvaccinated people increases the risk of infection from COVID-19. I acknowledge that I am aware of the risks involved and give consent to receive a massage from this practitioner. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to proceed with providing care. _____

I understand that masks are not required for fully vaccinated individuals but *are* required for those who are unvaccinated. Proof of vaccination (e.g. a vaccination card) is not required, but by signing below, I self-attest that my vaccination status as indicated on page 1 is true. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM THIS PROVIDERS FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

I UNDERSTAND THAT MY NAME AND CONTACT INFORMATION MIGHT BE SHARED WITH THE STATE HEALTH DEPARTMENT IN THE EVENT THAT A CLIENT OR PRACTITIONER AT THIS FACILITY 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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