COVID 19 CONSENT FORM

I, _____ do NOT have any of the following symptoms:

•Fever
•New onset of cough
•Worsening chronic cough
•Difficulty breathing
•Shortness of breath
•Sore throat
•Difficulty swallowing
•Decrease or loss of sense of taste or smell
•Chills
•Headaches
•Unexplained fatigue/malaise/muscle aches (myalgias)
•Nausea, vomiting, diarrhea, abdominal pain
•Pink eye (conjunctivitis)
•Runny nose/nasal congestion without other known cause
•If you are over 70 years of age, have you experienced any of the following: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions.

I, _____agree to the following:

•I understand the above symptoms and affirm that I, as well as all household members do not currently have, nor have experienced the symptoms listed above within the last 14 days.
•I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 30 days.
•I affirm that I, as well as household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
•I affirm that I, as well as all household members, have not travelled outside of the country or to any city outside of our own, that it is or has been considered a “hot spot” for COVID-19 infections within the last 30 days.
•I understand that this business cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below, I agree to each above statement and release the therapist and this business from all liability for the unintentional exposure or harm due to COVID-19. The therapist and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have expanded our sanitation protocols to fight the spread of COVID-19.

Signature:_____Date:_____