SOLACE ORGANIC SPA

Covid-19 Screening Questions, Consent & Liability Waiver

1. Do you have 2 or more of the following cold, flu or covid-like symptoms? **YES** **NO**

New or worsening, even mild ones: fever, chills, cough, shortness of breath, sore throat and painful swallowing, stuffy or runny nose, loss of sense of smell, red or pink eyes, diarrhea, dizziness, headache, muscle aches, fatigue, or loss of appetite.

2. If you currently have any of the above symptoms have you recently had a negative COVID-19 test? **YES** **NO**

3. Are you experiencing any of the following? **YES** **NO**

Severe difficulty breathing; e.g. struggling for each breath, speaking in single words, having a very hard time waking up, feeling confused, lost consciousness?

4. Are you experiencing any of the following? **YES** **NO**

Mild to moderate shortness of breath, inability to lie down due to difficulty breathing, chronic health conditions that you are having difficulty managing because of difficulty breathing?

5. Do you have a fever over 37.5 degrees celsius? **YES** **NO**

6. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? **YES** **NO**

If yes, did you wear PPE and please explain? _____

7. What health region or city are you visiting us from? _____

8. Consent to Treatment

I understand that this business and my therapist professional have taken all reasonable precautions to minimize the risk of exposure to COVID-19. Despite these precautions, I understand that there is no way to eliminate the risk completely. I consent to today's treatment/session.

I Understand and Agree **IF YES, PLEASE INITIAL** _____

9. Covid-19 Consent and Liability Waiver

I have read and understood the terms and conditions of this Covid-19 Consent and Liability Waiver.
I confirm that the information I have provided is true and accurate to the best of my knowledge.
As witnessed by my signature below, I agree to these terms and conditions.

PRINT FULL LEGAL NAME: _____

SIGNATURE: _____ **DATE:** _____