**COVID-19 Health Information & Liability Waiver**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

1. Have you had a fever in the last 24 hours of 100⁰ F or above? \_\_\_\_\_Yes \_\_\_\_\_No
2. Have you had any of the following symptoms within the last 14 days: any respiratory or flu symptoms, a new cough, a worsening chronic cough, shortness of breath, difficulty breathing? \_\_\_\_\_Yes \_\_\_\_\_No
3. Within the last 14 days, have you had close contact with anyone with acute respiratory illness or who has been diagnosed with covid-19? \_\_\_\_\_Yes \_\_\_\_\_No
4. Do you have two or more of the following symptoms: sore throat, runny nose/sneezing, nasal congestion, hoarse voice, difficulty swallowing, decrease or loss of sense of smell or taste, chills, headache, unexplained fatigue/malaise, diarrhea, abdominal pain, or nausea/vomiting? \_\_\_\_\_Yes \_\_\_\_\_No
5. If you are over 65, are you experiencing any of the following: delirium, falls, acute functional decline, or worsening of chronic conditions? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_N/A
6. Have you travelled outside of Massachusetts in the last 14 days? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, when and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have or have you had covid-19? If you *had* covid-19, your therapist will ask for more details about the timing and course of your illness. \_\_\_\_\_Yes \_\_\_\_\_\_No
2. Have you been fully vaccinated against covid-19? \_\_\_\_\_Yes, Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_No

**Contact Tracing**

We request that you let us know if you come down with covid-19 within 14 days of being at Bodyography, so that we can notify the Board of Health for contact tracing and do a deep cleaning of our space. If we learn that someone came down with covid-19 around the time that you were here, we will give your name and contact information to the Board of Health for contact tracing.

**Consent to Treatment/Liability Waiver**

I understand that, because massage therapy and other bodywork 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. I also understand that, while the staff at Bodyography Wellness Center LLC is taking all reasonable precautions to clean and disinfect the Center, there is no guarantee that I will not come into contact with 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 staff and Bodyography Wellness Center LLC from any claims related thereto. I give my consent to treatment from this practitioner.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (in case of a minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_