covid consent form

screening

Y	N	
☐	☐	*persistent dry cough*
☐	☐	*fever in last 7 days?*
☐	☐	*loss of smell and taste*
☐	☐	*have you been in contact with anyone with COVID in last 14 days?*
☐	☐	*have you been told to self-isolate?*
☐	☐	*do you, or anyone you live with or care fall under the clinically vulnerable list?*

consent

i understand that my treatment may involve touch and close proximity over an extended period of time, there may be an elevated risk of disease transmission, including covid-19

i give my consent to receive treatment from this practitioner

name

practioner name

signature

signature

date

date