Blue Sage Precautionary COVID-19 Client Form

Due to the global outbreak of COVID-19, we are taking extra precautions to keep all clients and staff safe. **Please carefully read and complete and sign the form below**. We appreciate your understanding.

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

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

* Have you experienced any fever (over 99.5) in the past 48 hours?

Yes No

* Have you or anyone in your household experienced any symptoms of COVID-19 in the past 14 days? Symptoms include:
* Fever Diarrhea
* Sore Throat Fatigue
* Loss of taste or smell Dry Cough
* Difficulty Breathing

Yes No

* Have you been around anyone who has tested positive for COVID-19 within the past 14 days?

Yes No

* Have you or any household member traveled outside of the country or to any city outside of our own that has been considered a “hot spot” for COVID-19 infections within the past 14 days?

Yes No

* Are you currently awaiting results for a COVID-19 test?

Yes No

* I understand Blue Sage Massage and Day Spa and my service provider 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.

Yes No

By signing below, I understand that close contact with people increases the risk of infection from COVID-19. I acknowledge that I am aware of the risks involved and give consent to receive treatments from Blue Sage Massage and Day Spa and their Service Providers.  I release the Service Provider(s) and the business from all liability for the unintentional exposure or harm due to COVID-19.

I understand that my name and contact information might be shared with the state health department in the event that a client or service provider 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_