COVID-19 Health Screening Symptom Checker

Must Be Completed each day you have a scheduled appointment, please complete at least 2 hours prior to your appointment time

Name *

First Name Last Name

Today's Date *

Month Day Year

COVID-19 Information

Have you had a fever of or above 100.4F in the last 24 hours? By answering "no" you are verifying that you have taken your temperature at home and recorded it to be under 100.4F *

Yes

No

I need you to take my temp at the door on arrival.

Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, change in your sense of taste or smell, or shortness of breath? *

Are you prone to respiratory distress of any kind? *

Yes

No

Have you traveled on public transportation or attended an event outside of New Hampshire in the last 14 days? If yes it is suggested to self quarantine for 14 days, and prior to scheduling. *

Yes

No

Have you or anyone you have been in contact with in the last 14 days been diagnosed with COVID-19 or coronavirus-type symptoms? *

Yes

No

Have you been immune compromised at all in the past week? If yes, please explain in the "other" box below. *

Yes

No

I consent to being documented as a client here today in the event that contract tracing needs to occur. *

Yes

No

I have a clean designated mask/face covering for this treatment to use for my session today. *

Yes

No, I need one when I arrive

I agree to contact my practitioner if I am informed within 14days after my appointment that I have tested positive for COVID-19, or someone that I had been in contact with before my appointment has tested positive for COVID-19.

I agree to the above statement. *

Yes

No

COVID-19 is a highly contagious virus that spreads from person to person. In addition to long-held and explicit sanitation measures this business has always adhered to, new preventative measures have been put in place to further reduce the spread of this novel virus. However, these best practices still offer no guarantee regarding your potential risk of being infected. PLEASE SEE YOUR SERVICE WAIVER AGAIN, SHOULD YOU HAVE ANY QUESTIONS.

I agree to the above statement. *

Yes

No

Consent for Treatment

NEW FORM FOR EVERY TREATMENT

I agree to the above statement. *

Yes

No

I understand the because Massage and Bodywork involve maintained touch and close physical proximity over;an extended period of time, there may be an elevated risk of disease transmission, including but not limited to;COVID-19. By signing this form, checking yes you understand and/or submitting the form. I acknowledge that I;am aware of the risks involved from receiving treatment and voluntarily agree to assume those risks, and I;release and hold harmless my practitioner and 444Hands from any claims related thereto. I give my consent;to receive treatment and to follow all guidelines asked of me today.