Health Information: COVID-19 Consent Form

Client Name

Please Print:

Date D D M M Y Y Y Y

COVID-19 Screening Information - Tick as appropriate

1. Have you had a fever in the last 7 days? Yes ◯ No ◯
   (Feeling hot to touch on your chest and back)

2. Do you now, or have you recently had, a persistent dry cough? Yes ◯ No ◯
   (Coughing a lot for more than an hour, 3 or more coughing episodes in 24 hours or worsening of a pre-existing cough)

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus type symptoms? Yes ◯ No ◯

4. Have you been told to stay home, self-isloate or self-quarantine? Yes ◯ No ◯

5 . Do you have any other symptoms that may mean you have a COVID-19 infection? Yes ◯ No ◯
   (Loss of taste and smell. unusual fatigue or shortness of breath)

Consent for Treatment

I understand that, because my treatment may involve touch and close physical 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.

Your Name

I am Patient ◯ Parent / Guardian / Carer ◯

Name of Practitioner

Signed

Date D D M M Y Y Y Y