Restorative Medical Massage Therapy

524 South Ave. East, Cranford NJ 07016

COVID-19 Health Screening/Information and Informed Consent

Patient Name: _____ DOB: _____ Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer there COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes __ No __

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes __ No __

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 traveled anywhere outside of the state in the last two weeks? Yes __ No __

   If yes, Location: _____

5. Have you had a new loss of sense of taste or smell? Yes __ No __

The following questions are specific to a new aspect of COVID-19 involving blood coagulation (clotting)

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes __ No __

7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes __ No __

8. Have you seen any new marks, rashes, spots, bumps or other lesions on your skin? Yes __ No __

Consent for Treatment

I understand that, because massage therapy work involves maintained touch and close proximity over an extended period of time, there may be an elevated risk of disease transmission, including 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 practitioner/Restorative Medical Massage Therapy from any claims related thereto. I give my consent to receive treatment from this practitioner/Restorative Medical Massage Therapy.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (incase of a minor: _____ Date: _____