**Covid-19 Exposure Control, Mitigation & Recovery Plan**

***COVID-19 Screening Addendum & Informed Consent (Ask for a Copy if you Would Like One)***

Client Name: _____ 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.**

Please check if you have any of the following conditions (**Clients with any of these conditions are informed that they could be at higher risk and encouraged to weigh the risks and benefits of massage with their doctors.**): _____ (Initial)

*Currently **Known** High-Risk Categories (per CDC)*

Please check if you have any of the following conditions:

_____ COPD
_____ Serious Heart Condition
_____ Obesity (BMI 30+)
_____ Chronic Kidney Disease
_____ Immunocompromised from solid organ transplant
_____ Sickle-Cell Disease
_____ Type 2 Diabetes
_____ Cancer

*Currently Thought **Possible** High-Risk Categories (per CDC)*

_____ Asthma (Moderate to Severe)
_____ Cystic Fibrosis
_____ Liver Disease
_____ Pregnancy
_____ Smoking
_____ Type 1 Diabetes
_____ Immunocompromised for reasons other than solid organ transplant
_____ Cerebrovascular Disease
_____ High Blood Pressure
_____ Neurologic Conditions (such as dementia)
_____ Pulmonary Fibrosis
_____ Thalassemia (type of blood disorder)

***Age as a Risk Factor***

Please be informed that risk of severe illness with Covid-19 increases with age. 8 out of 10 deaths are in those over 65. The greatest risk is for those over 85.

Everyone is encouraged to discuss their age, health conditions and level of risk with their doctors to make the best decision in seeking massage. _____ (Initial)

***Other Health Screening Questions***

Have you been diagnosed with Covid-19? _____ If so, when? _____

Have you had a fever in the last 24 hours of 100°F or above? _____

Please check any of the following you now have, or have recently had, as a NEW PATTERN since the emergence of the pandemic:

_____ Fever or chills
_____ Muscle or body aches
_____ Cough
_____ Nasal, sinus congestion or runny nose
_____ Diarrhea, digestive upset
_____ New loss of sense of taste or smell

_____ Sore Throat
_____ Fatigue
_____ Headache
_____ Shortness of breath/trouble breathing
_____ Nausea or vomiting

***The following questions are specific to an aspect of COVID-19 involving blood clotting risk:***

Do you have a history of blood clots? _____

Do you have any new discomfort with exertion or exercise? _____

Have you had a new onset of muscle aches and pain since the emergence of the virus? _____

Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin or mouth? _____

***Contact Question***

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

**Consent for Treatment-Please Take Your Time & Read Carefully**

To proceed with receiving care, I confirm and understand the following **(Initial in all places provided)**:

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner has provided me here with information to assist me in making informed choices, and is available for questions. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

**Contact Tracing:** I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner 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. _____

I will also let the practitioner know asap or give the practitioner’s name to a contact tracing team if I develop cold or flu-like symptoms or test positive for Covid-19 within 14 days following any session. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____