COVID-19 CONSENT FORM

1. Have you had a fever in the last 24 hours of 100°F or higher?

YES **NO**

2. Do you now, or have you recently had any respiratory or flu-like symptoms – including sore throat, shortness of breath, difficulty breathing, tightness in chest.

YES **NO**

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

YES **NO**

CONSENT FOR TREATMENT

I understand that because aesthetics involves maintained touch and close physical 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 during this time. I voluntarily agree to assume those risks and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature:_____ Date: _____

Signature of Parent/Guardian (in case of minor): _____

Print Client Name: _____