HEALTH SCREENING & COVID-19 CONSENT FORM

Client Name
Address
Mobile
Email address

Please tick “yes” or “no” to answer the questions below.

Have you had a fever in the last 7 days? (feeling hot to touch, on the chest and back)	☐ YES	☐ NO
Do you now, or have you recently had a persistent dry cough? (coughing a lot more than an hour or 3 or more coughing episodes in 24hr or a worsening of a pre-existing cough)	☐ YES	☐ NO
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
Have you been told to stay home, self-isolate or self-quarantine?	☐ YES	☐ NO
Do you have any other symptoms that may mean you have a Covid-19 infection? (loss of taste and smell, unusual fatigue or shortness of breath)	☐ YES	☐ NO
Do you or anyone that you live with fall into the “clinically vulnerable” or “clinically extremely vulnerable” categories and therefore advised to shield at home by the Government?	☐ YES	☐ NO

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.

In the eventuality that the practitioner gets symptoms of Covid-19 within 48 hrs of having close contact with me and then they later tested positive, the practitioner is obliged under law to provide my name, phone number or email and the date and time of my visit to the test and trace service.

I give my consent to receive treatment from Nicoletta Zinato. I confirm that I am over 18 years old.

Print Name

Signed

Date