COVID - 19 Client Consent Form

I, _____ (the patient), consent to receive beauty treatment services during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID - 19 including how it spreads and is transmitted.

I understand that based on what is currently known about COVID - 19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that due to the unknowns of this virus, the number of the other clients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by receiving treatment in the practice.

COVID-19 affects different people in different ways. Infected people have a wide range of symptoms reported from mild symptoms to severe illness. Symptoms that may appear 2-14 days after exposure to the virus:

- Fever
- Chills
- Cough
- Muscle Pain
- Headache
- Sore Throat
- Shortness of Breath
- Difficulty Breathing
- Shaking with Chills
- Loss of Taste or Smell

If you develop any of these COVID-19 symptoms please seek medical attention immediately:

- Difficulty Breathing
- Persistent Pain/Pressure in Chest
- New Confusion/Inability to Arouse
- Bluish Lips/Face
- _____New/Other
- _____New/Other

I confirm that I do not display or currently have any of the symptoms that represent of COVID-19, which are outlined above: _____ (Initial)

I understand that all travelers arriving from any country or region with widespread ongoing transmission, as outlined by the CDC are required to self-quarantine for 14 days to practice social distancing and monitor

their health after their arrival. I confirm that I have not traveled outside the country in the past 14 days: _____ (Initial)

By signing below I am agreeing to release all liability to NAME OF BUSINESS, in the event I am unknowingly exposed to COVID-19.

Patient Name: _____Date: _____

Patient/Guardian Signature: _____Date: _____

Artist Signature: _____ Date: _____