COVID-19 CONSENT FORM

JUNE 2020

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and may still be contagious.

I understand that the therapy: Athletic Therapy, Chiropractic, Massage Therapy, Physiotherapy, or Osteopathy treatment is in a closed room and may bring the practitioner and the client close to each other for several minutes at a time and that this is a risk factor for both individuals. The treatment room will be well ventilated to minimize these risks.

I understand that as a client I will wear a mask while in the clinic and that the therapist will be required to have further personal protective equipment (PPE) that includes a mask, eye protection, face shield, and gloves where necessary during treatment. The benefit of this is further protection and risk management during treatment.

I understand that treatment is indicated, and I will potentially benefit from the treatments.

I am aware that certain conditions are considered high risk factors and includes: diabetes, cardiovascular disease, hypertension, lung diseases, asthma, immuno-compromised conditions, having active malignancy, or being over 65 years old.

I understand that any travel outside of Canada, by car, air, bus or train, significantly increases my risk of contracting and transmitting COVID 19. IF so, 14 days of self-isolation is required by law.
_____ (initial)

I confirm that I'm not currently positive for COVID 19. _____ (initial)

I confirm I am not waiting for laboratory test results for COVID 19. _____ (initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or has been asked to self-isolate. _____ (initial)

I DO NOT PRESENT WITH:

- Fever >38°C _____ (initial)
- Cough _____ (initial)
- Sore throat _____ (initial)
- Shortness of Breath _____ (initial)

- Difficulty Breathing _____ (initial)
- Flu-like symptoms _____ (initial)
- Runny nose _____ (initial)

I verify that the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to treatment as described and discussed with the practitioner during the COVID -19 pandemic.

_____
PRINTED NAME

_____
SIGNATURE OF CLIENT

_____
DATE