

COVID-19 EVALUATION FORM

It is imperative that we can track our guests and screen to lower the risk of exposure to COVID-19. In order to be in compliance with the health and safety rules as suggested by the government, it is mandatory that you are not allowed to enter the salon if you answer yes to ANY of the following questions or are experiencing or have experienced any flu-like symptoms in the last 14 days.

Date _____ Time _____
Name _____ Cell _____
Email _____ Temperature _____

- Have you had a fever in the last 14 days? **YES or NO**
- Have you had a Cough in the last 14 days? **YES or NO**
- Have you been around anyone exhibiting these symptoms? **YES or NO**
- Have come in direct contact with someone who has been diagnosed with the COVID-19 within the past 14 days? **YES or NO**
- Are you living with someone who is sick or quarantined? **YES or NO**
- Are you willing to comply with our updated rules of sanitation? **YES or NO**

As your professional hair care service provider, I am stating and confirming that I have not experienced any of the above-mentioned symptoms within the last 14 days. I am further stating I will also comply to the new norm safety rules and practices.

We appreciate your commitment to lowering the risk to exposure of COVID-19. We are truly in this together.

Guest Name (Print)

Stylist/Staff(Print)

Guest Signature

Stylist/Staff Signature

Date

Date