Anne Speer
Integrative Bodywork
CranioSacral Therapy

Health Information-COVID-19 Information & Liability Waiver

Client Name: _____

I understand that I need to reschedule my appointment if I have developed a fever or any symptoms of a cold, flu or any other COVID-19 related symptoms 24-48 hours prior to my appointment.

Consent for Treatment
I understand that, because massage therapy work 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 at 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 consent to receive treatment from this practitioner on this date and in the future.

Client Signature _____ Date _____

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

Consent in case of COVID-19 exposure
I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Signature _____ Date _____

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