COVID-19 PRE-SCREENING

***Please show RMT this form when complete through the window

1.	Do you have **ANY** of the following symptoms:	YES	NO
	• Fever / chills		
	• Cough		
	• Shortness of breath / difficulty breathing		
	• Overall feeling of being unwell		
	• Conjunctivitis (Pink eye)		
	• Runny nose / sneezing / nasal congestion with unknown cause		
	• NEW muscle pain (with unknown cause)		
	• NEW headaches (with unknown cause)		
	• Sore throat / swelling of throat / difficulty swallowing		
	• NEW loss of taste or smell		
2.	• **Have you:**		
	• Tested positive for COVID-19 in the past 40 days		
	• Knowingly been exposed to someone with COVID-19 in the past 2 weeks		
	• Recently traveled to an area with a high infection rate		
	• Been in an area of higher risk where social distancing was not possible without a mask or proper PPE		
	• Been to a **Nursing Home** where social distancing was not possible without a mask or proper PPE		
	• Care for an individual who is currently ill with COVID-19 without proper PPE?		

If you have answered **YES** to any of the above questions Please **circle below:**

YES

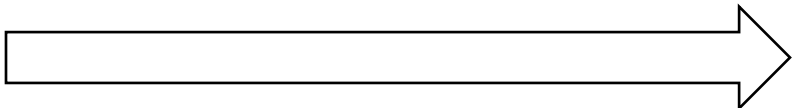
IF YOU HAVE CIRCLED **YES**, PLEASE KINDLY RETURN HOME AND CALL OUR OFFICE TO RESCHEDULE YOUR APPOINTMENT IN 2 WEEKS.

For our general knowledge:

- Does anyone in your home have any symptoms from question 1 & 2? **Yes No**
- Do you work in a Nursing home / Long term care facility / Healthcare facility? **Yes No**
- Are you a care provider for any individual who is currently ill with COVID-19? **Yes No**

I understand the above questionnaire and have answered the above truthfully.

Print Name _____Signature: _____Date: _____



COVID-19 RISK INFORMED CONSENT

I _____ (Insert Name) understand that, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact and, as a result, Federal Health agencies recommend social distancing. It is important to be aware that although significant precautions have been taken in accordance with the Government of Ontario health regulations, as well as the College of Massage Therapists of Ontario (CMTO) to limit the risk of exposure to the virus during your massage session through symptom pre-screening and infection control guidelines, the risk is not zero.
Individuals may be infected with the virus and show no symptoms, and the incubation period is up to 14 days.
I recognize that the Registered Massage Therapist that I am to be treated by as well as the staff at Sandelli Massage Therapy & Associates are closely monitoring this situation and have put in place mandatory preventative measures aimed to reduce the spread of COVID-19.
I verify that I understand that protocols are in place to decrease the transmission COVID-19, but that the risk cannot be reduced to zero, as massage therapists will not be able to remain 2 meters away from their clients.

I verify that I have read the above statements and fully understand the risks involved with receiving Massage Therapy. I verify that I believe the benefits of Massage Therapy to outweigh the risks.
**I understand my RMT may choose to not treat, or stop the treatment if at anytime I seem unwell, unsafe to treat, or have discussed verbally a situation that raises any COVID-19 transmission concern.

I hereby release and agree to hold all members of Sandelli Massage Therapy & Associates harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the practice, or that may otherwise arise in any way in connection with any services received from Sandelli Massage Therapy & Associates. I understand that this release discharges Sandelli Massage Therapy & Associates from any liability or claim that I, my heirs, or any personal representatives may have against the practice with respect to any bodily injury, illness, death, medical treatment, or damage that may arise from, or in connection to, any services received from any RMT at Sandelli Massage Therapy & Associates. This liability waiver and release extends to the practice together with all RMTs, employees and owner.

I have been given the opportunity to ask questions about the pros/cons/risks of receiving a massage and all of my questions have been answered to my satisfaction.

Print Name: _____ Signature: _____

Date: _____