



PRECAUTIONARY COVID-19 LIABILITY RELEASE FORM

Please Note: The Salt Lake Health Department has access to this form at any given point

Symptoms of COVID-19 CAN include:

- | | |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Dry Cough |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Muscle Aches & Pains |
| <input type="checkbox"/> Decreased Sense of Smell / Taste | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Red or Purple Toes | <input type="checkbox"/> Confusion / Inability to Arouse |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bruising, Redness, Swelling, or Cramping in Legs or Feet | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Nausea & Vomiting |
| <input type="checkbox"/> Chest Pain or Pressure | <input type="checkbox"/> Blushed Lips or Face |
| <input type="checkbox"/> Flu-like Symptoms | <input type="checkbox"/> RELIEF of <u>Usual</u> Aches & Pains |

I, _____ agree to the following:

- 1) I understand the above symptoms and affirm that I, and all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days. (Initials)_____
- 2) I affirm that I, and all household members, have not been diagnosed with COVID-19 within the last 14 days. (Initials)_____
- 3) I affirm that I, and all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 14 days (this includes any notifications of possible exposure). (Initials)_____
- 4) I affirm that I, and all household members, have not traveled to any city that is or has been considered a “hot spot” for COVID-19 infections within the last 14 days. (Initials)_____
- 5) I affirm that I, and all household members, have not had medical or dental care that required removal of our face mask in the last 2 weeks. (Initials)_____
- 6) I affirm that I, and all household members, actively engage in social distancing and mask precautions. (Initials)_____
- 7) I affirm that I am either:
 - Not in an elevated at-risk category (including, but not limited to, those with compromised immune systems, those with conditions such as heart disease, lung disease, diabetes, Parkinson’s, suppressed immune systems, or individuals over the age of 65). (Initials)_____
 - I AM in an elevated at-risk category, and I have informed Jenn of that, in order to arrange for a therapy session on a day when the studio has been inactive for several days. If I chose to come in on a different day, I am aware of the risks and assume responsibility for that decision. If my reason
 - for being in an elevated at-risk status is due to a medical condition, I am aware that this dramatically increases my chances of both getting an infection and having a more severe case. I am also aware that Jenn may refuse service without a doctor’s recommendation. I release Jenn of any and all liability in working with me due to this higher risk. (Initials)_____

Please see reverse side →

8) I affirm that:

- I have never had COVID-19 (Initials) _____
- I have had COVID-19 in the past. I am aware that this increases my chances of vascular issues. I release Jenn of any liability in working with me due to that higher risk. I understand that Jenn may refuse service without a doctor's recommendation, and I release Jennifer Jackson of any and all liability in working with me due to this higher risk. (Initials) _____

9) I affirm that I am not pregnant. (Initials) _____

10) I affirm that if I, or any of my household members work, our places of employment, and coworkers, support any health mandates in place, including wearing masks and social distancing.
(Initials) _____

11) Furthermore, I agree to notify Jennifer Jackson should I, or any of my household members, become ill with any of the above listed symptoms or if I, or any of my household members, am/are diagnosed with COVID-19 within the next 30 days. (Initials) _____

I agree to fully release Fusion Bodywork and Jennifer Jackson from all liability for any alleged or actual exposure to the Covid-19 virus or any other contagion. I understand that individuals infected with Covid-19 may be asymptomatic and agree to assume all responsibility for actual or potential exposure to the Covid-19 virus as a part of my treatment. I understand that massage therapy involves maintained touch and close physical proximity over an extended period of time, and as a result is an elevated risk of disease transmission including COVID-19.

By signing this form, I acknowledge that I am aware of the risks involved and give my informed consent to receive massage and bodywork from Jennifer Jackson. I also represent that I have answered these questions honestly and agree to fully release Jennifer Jackson and Fusion Bodywork from all liability for any exposure to or transmission of the Covid-19 virus and for any resulting conditions or illnesses caused as a result.

I understand that all persons under the age of 18 are required to have a parent or guardian fill out this form. If the client is under the age of 18, by signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s) at Fusion Bodywork.

Signature: _____ Date: _____

Phone #: _____ My Pre-Session Temperature _____

Time of Session: _____ Length of Session: _____