

COVID-19 Liability Release Waiver Form



Due to the 2019-2020 outbreak of the novel Coronavirus (COVID-19), our business is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfecting procedures in compliance with CDC guidance.

Full Name (in capitals) _____ **Date** _____

SYMPTOM WELLNESS CHECK

Have you ever experienced any of the following symptoms within the last 14 days?

Fever or feeling feverish, new cough, shortness of breath, flu-like symptoms such as fatigue, nausea, diarrhea? Chills? Repeating shaking chills? Muscle pain? Headache? Sore throat? New loss of taste or smell? Rash.

YES NO

Please circle all that apply

Have you been diagnosed or suspected of having Coronavirus or Covid-19?
If yes, when? _____

YES NO

Have you been tested for Coronavirus or COVID-19?

YES NO

If tested, was the testing performed by nasal swab or blood test? _____

If tested, did you test: Positive or Negative? _____

Have you had an antibody test for Coronavirus?

YES NO

If tested, did you test: Positive or Negative? _____

If known, was the test for IgM or IgG antibody? _____

FAMILY AND CLOSE CONTACTS

Are you, or anyone you live with, in a "high risk group"?

YES NO

Have any of your family members or immediate/close contacts currently sick or experiencing fever, cough, shortness of breath, or flu-like symptoms (sore throat, muscle aches, fatigue, nausea and diarrhea)?

YES NO

Have any of your family members or immediate/close contacts been diagnosed with Coronavirus or COVID-19?

YES NO

Have you been exposed to anyone who has had COVID-19 in the past 4 weeks?

YES NO

RECENT TRAVEL

Have you travelled outside the UK in the past 14 days?

YES NO

If yes, where have you been? _____

Have any of your family members travelled outside the UK in the past 14 days?

YES NO

If yes, where have you been? _____

- I understand that I am required to wear a face mask to my appointment YES NO
- I understand COVID-19 virus has a long incubation period. Carriers may not show any symptoms of the virus but can still be highly contagious. YES NO
- I knowingly consent to having a service at **Gosh Gosh PMU & Training** during the COVID-19 pandemic. YES NO
- I understand that I will need to review, resign and date this form before every future appointment. YES NO
- I understand **Gosh Gosh PMU & Training** has taken all necessary precautions to prevent the spread of COVID-19 and will not hold the salon liable for exposure of the virus. YES NO
- I understand I will need to follow the salon guidelines to prevent the spread of COVID-19 YES NO
- I acknowledge that the information I have given is accurate and complete. I am happy to proceed with my treatment. YES NO

Client / Model Signature _____ **Client / Model Date** _____