Screening Questions, please mark Yes or No in the space provided. Your therapist will also fill in this screening for your appointment.				
	Client		Therapist	
	Yes	No	Yes	No
Are you experiencing any of the following? Fever, new onset or worsening cough, sore throat Sneezing, running nose, difficulty breathing, headache, muscle aches, severe fatigue, vomiting, diarrhea, loss of smell or taste				
Have you travelled or had close contact with anyone that has traveled outside of the province of BC within the last 14 days?				
Did you provide care or have close contact I with a person with COVID 19 (confirmed or presumptive) within the last 14 days?				
Did you have close contact with a person who travelled outside Canada in the last 14 days?				
Do you have a temperature outside of the normal range? (36.1 C to 37.2 C)				
Are you a front line worker or see large numbers of people in a day?				
Please initial to verify your response				

- I understand that if I answer Yes to any of the above questions that my treatment may be cancelled and you may be required to follow the 14 day quarantine before you can attend another treatment.
- I understand and have had the new protocols explained to me and I am aware of my part in helping to maintain a safe environment. I am aware that based on my answers to the above questions I may be asked to wear a mask for the duration of my treatment.
- I understand I have the right to ask my Therapist to wear a mask/eyewear during my treatment.
- I understand that in order for my Massage Therapist to provide treatments, they will not be able to practice physical distancing.
- I understand that even with the new office protocols for distancing, additional cleaning and personal protective equipment, there is still a risk of contracting COVID 19 while at this clinic or receiving treatment.

By signing this form I acknowledge that I am aware of the risks involved and voluntarily give consent to receive my massage today. I release my Massage Therapist and Tri Lake Massage and Wellness from any liability If I were to contract COVID 19. I understand that if I am confirmed positive for COVID 19, I will notify my Therapist immediately and give permission to share my personal information for contact tracing.

This document has been explained to me and I have had a chance to ask questions of my Therapist. By signing this I acknowledge the above bullets and give my consent to continue with the treatment.

Patient Name (please print). _____. Date. _____

Signature of Patient. (or Guardian). _____