

Touch of Europe Spa Mandatory Covid19 Form. Must be completed before first visit.

Date: _____ Time: _____

Client's First and Last Name: _____

Cell Phone #: _____ EmailAddress: _____

Today's Service(s) scheduled: _____

Name(s) of Therapist(s) scheduled with: _____

1. Have you tested positive to Covid19?

YES NO

*If Yes when? _____ Minimum 14 days post positive testing required before we may service you and with absolutely no symptoms present for a minimum of consecutive 3 days.

2. Have you been in contact with anyone diagnosed with Covid19 within the last 14 days?

YES NO

3. Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing)?

YES NO

Date: _____ Signature: _____

If the answer is Yes to any to any of the above, access to the facility will be denied and we will kindly ask you to reschedule. By signing the above you also agree not to show up to any future appointment(s) at our facility if the answer to any of the above is YES.

Liability Waiver:

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by my mere presence within this establishment and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, employees, volunteers, and program participants and their families. I hereby release the Touch of Europe Spa, its owner(s) and staff members from any and all claims arising from or in connection with any direct COVID-19 impact while visiting.

Date: _____ Time: _____

First Name: _____ Last Name: _____ Signature: _____

To be completed by Touch of Europe Spa Staff Member:

Access to facility
Staff Member Signature: _____

Approved By: _____

Denied By: _____