Gaenor Farren-Smith MAcS

Health Information: Covid-19 Consent Form.

Name

Date

1. Have you had a fever in the last 7 days? **(feeling hot to touch on your chest and back. Or had a high temperature over 37.5)**

   Yes / No

2. Do you now, or have you recently had, a persistent dry cough? **(coughing a lot for more than an hour, 3 or more coughing episodes in 24 hours or worsening of a pre-existing cough)**

   Yes / No

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?

   Yes / No

4. Have you been told to stay at home, self-isolate or self-quarantine?

   Yes/ No

5. Do you have any other symptoms that may mean you have a Covid19 infection **(eg. Loss of sense of smell, unusual fatigue or shortness of breath)**

   Yes / No

Consent for Treatment

I understand that, because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission including Covid-19.

I understand that the practitioner cannot accept responsibility for the transmission of the Coronavirus (Covid-19) should I become infected.

I give my consent to receive treatment.

Signed:

Please email back to the practitioner at gaenor@MyAcuCare.co.uk