



COVID-19 CONSENT FORM

1. Have you had a fever in the last 24 hours of 100°F or higher?

YES NO

2. Do you now, or have you recently had any respiratory or flu-like symptoms – including sore throat, shortness of breath, difficulty breathing, tightness in chest.

YES NO

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

YES NO

CONSENT FOR TREATMENT

I understand that because aesthetics involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment during this time. I voluntarily agree to assume those risks and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature:

Date:

Signature of Parent/Guardian (in case of minor):

Date:

Print Client Name: