Colorado School of Healing Arts

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Clinic COVID-19 Health Informed Consent, Information, and Screening

Client Name: _____ Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and accurately and let us know if you have any questions.

Consent for Treatment

- I understand that I am required to wear masks the entire time I am in the building during the massage even while face-down in the cradle during the massage.
- I understand that I will be screened and required to complete a release form each visit - which includes a temperature check and COVID-19 related questionnaire.
- I understand if I have any symptoms, including uncontrolled allergies, CSHA will cancel my appointment immediately with no charge.
- I understand that the Student Therapists and the Clinic Director will also be wearing masks.
- I understand that once I am on the massage table, the Student Therapist will leave the door slightly ajar for increased air ventilation.
- I understand that talking will be kept at a minimum; and I agree to limit my conversation to feedback for my therapist.
- I understand that due to mask wearing, we will limit massage around the face and neck.
- I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented.
- I understand that because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19.

I HEREBY ACKNOWLEDGE AND ASSUME THE RISK OF BECOMING INFECTED WITH COVID-19 AND GIVE MY EXPRESS PERMISSION TO COLORADO SCHOOL OF HEALING ARTS AND MY STUDENT MASSAGE THERAPISTS TO PROCEED WITH PROVIDING STUDENT MASSAGE THERAPY.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, ASSUME THE RISK AND AGREE TO THE CONDITIONS LISTED ABOVE

Client Signature: _____ Date: _____

CSHA Signature: _____ Date: _____

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CLINIC COVID 19 Screening FORM

Client Name: _____ Date: _____

Client Current Temperature: _____ (Clinic Director will fill in)

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Circle: Yes / No

2. Do you now, or have you in the last 14 days, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Circle: 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? Circle: Yes / No

4. Have you traveled anywhere outside of the state /country in the last two weeks? Circle: Yes / No

Location: _____

5. Have you had a new loss of sense of taste or smell? Circle: Yes / No

6. Do you have a new concern with being able to exercise to get your heart rate and respiratory rate up without any problem? Circle: Yes / No

7. Have you had a new onset of muscle or joint aches or pains in the last 14 days? Circle: Yes / No

8. In the last 14 days have you seen any new rashes, spots, bruises, or other lesions on your skin or toes?

Circle: Yes / No

Client is given permission to receive Student Massage Circle: Yes / No

CSHA Signature: _____Date: _____