

Colorado School of Healing Arts

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 COVID19 public health crisis. Please read and fill out this form carefully and accurately and let us know if you have any questions. **Due to the possible complications from COVID 19, if you have recovered from any COVID-19 infection, please contact the school to talk with the clinic director, PRIOR to your appointment, so we can determine the type of massage we can offer you.**

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: _____

Clinic Director Signature: _____ Date: _____

Colorado School of Healing Arts
CLINIC COVID 19 Screening FORM

Client Name: _____ Date: _____

Client Current Temperature: _____ (Therapist will fill in)

Please answer these COVID-19 health questions below:

1. Have you had COVID-19? Circle: Yes / No

If yes, please call the Clinic Director: 303-986-2320 x58

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

3. 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

4. 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

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

Location: _____

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

7. 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

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

9. 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