**(COVID-19) Client Pre-Consultation Form**

To help prevent the spread of COVID-19 in the clinic and local community, I will ask each client to review the questions on this form prior to attending for treatment / yoga class. If you answer YES to any of the questions, please let me know immediately and we can discuss a suitable future appointment / date for your treatment / class. N.B. Every question **must** be answered. On arrival to your treatment / class you will be asked to sign this form. I will have a copy for you to sign or you can print the form, sign it and bring it with you to the treatment / class.

I have taken extra measures to safeguard my clients prior to arrival. I kindly ask you to complete this declaration for the safety of me & my clients.

|  |  |
| --- | --- |
| Client Name: | Client Mobile Number: |

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| --- | --- | --- |
| **QUESTION** | **YES** | **NO** |
| Do you have symptoms of cough, fever, high temperature, sore throat,  runny nose, breathlessness or flu like symptoms now or in the past 14 days? |  |  |
| Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days? |  |  |
| Have you been in close contact with a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less than 2 metres for more than 15 minutes accumulative in 1 day)? |  |  |
| Do you consider yourself to be in the category of people at higher risk from coronavirus?  If you are unsure whether or not you are in an at-risk category, please check with your doctor. |  |  |
| If your situation changes after you complete and submit this form you agree to inform your therapist. |  |  |

Please enter any other information you feel is relevant

**\*\*Vaccination information: It is not advisable to attend for treatment or class during the first three days after vaccination especially if the person is showing side-effects\*\***

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**CONSENT FORM:**

I understand that COVID-19 is highly contagious and still present in the community where I am seeking reflexology / yoga. I understand that COVID-19 is passed through close contact with others. I understand that this therapist has taken every precaution to ensure my health and safety.  
I also understand that my personal details will be held securely under GDPR and may be used for Contact Tracing process if necessary.

…………………………………………………….Client’s signature / Date ……………………………………..