COVID-19 SCREENING & DISCLAIMER FORM

For the health and safety of myself and my clients, I am implementing additional measures in compliance with the precautions published by both the UK and Scottish Governments in respect of the disease known as coronavirus disease (COVID-19) and the virus known as Severe Acute Respiratory syndrome coronavirus 2 (SARS-CoV-2) ("Coronavirus").

To the best of my knowledge, I, _____ *(therapist's name)* do not currently have Covid-19, nor have I been in contact with anyone with Covid-19, or anyone displaying any symptoms of Covid-19.
If this changes, and either I or one of my clients test positive, I will inform you immediately and we will both self-isolate for 14 days or until I know it is safe for me to return to work in accordance with the Scottish Government's Covid-19 Guidelines.

To be completed by client no more than 24 hours before every appointment:

CLIENT'S NAME:	
ADDRESS & POSTCODE:	
BEST CONTACT NO:	

Section 1

Since January 2020, have you had Covid-19? **YES** **NO**

If yes, please continue: **If no, please turn to Section 2**

Were you tested to confirm this diagnosis?	**YES**	**NO**
What date were you tested / diagnosed?		
Were you hospitalised, requiring oxygen?	**YES**	**NO**
Were you in ICU?	**YES**	**NO**
Did you require mechanical ventilation?	**YES**	**NO**
How long were you in ICU for?		
When were you discharged?		
Do you still have any symptoms of Covid-19?	**YES**	**NO**
Has a test confirmed you are now negative and thus free of Covid-19?	**YES**	**NO**
Have you been left with any lasting health restrictions such as shortness of breath, fatigue or difficulty lying down due to chest issues?	**YES**	**NO**
Have you been put on blood thinners such as Warfarin?	**YES**	**NO**
Do you consider yourself back to full health?	**YES**	**NO**
How would you best describe your health?		

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Section 2 - Are you currently experiencing ANY of the following symptoms?

A high temperature or fever?	**YES**	**NO**
A new continuous cough? (Coughing for longer than an hour, or three or more coughing episodes in 24 hours. If you usually have a cough, it may be worse than usual.)	**YES**	**NO**
A loss of, or change in sense of smell or taste?	**YES**	**NO**
Other symptoms may include:		
Unexplained shortness of breath and/or having breathing difficulties?	**YES**	**NO**
Unexplained sore throat, congestion or a runny nose?	**YES**	**NO**
Unexplained headaches, muscle or body aches, including leg cramps?	**YES**	**NO**
Unexplained rashes particularly on your feet?	**YES**	**NO**
Unexplained fatigue or exhaustion?	**YES**	**NO**
Unexplained inability to wake and stay awake?	**YES**	**NO**
Unexplained feeling of confusion?	**YES**	**NO**
Unexplained nausea or vomiting?	**YES**	**NO**
Unexplained diarrhoea?	**YES**	**NO**
Client shows symptoms of Covid-19: I cannot treat you at this time. Please isolate yourself and your family for 14 days, until all the symptoms have gone. Contact your GP for advice and ask to be tested to confirm Covid-19. Please contact me to rebook your treatment after this time.	**No symptoms:** Therapist treats Date: Initials:	

Section 3 - Are you at high risk from Covid-19 and shielding?

Having cancer treatments that lower the immune system? (e.g. chemotherapy, radiotherapy, immunotherapy, bone marrow or stem cell transplant)	**YES**	**NO**
Organ transplant or taking immune suppressants?	**YES**	**NO**
Have a severe respiratory condition? (e.g. cystic fibrosis, severe asthma, COPD)	**YES**	**NO**
Have a serious heart condition?	**YES**	**NO**

Section 4 - Are you clinically vulnerable or shielding someone who is vulnerable?

Are you 70 years or older?	**YES**	**NO**
Have a respiratory condition? (e.g. asthma, COPD, emphysema or bronchitis)	**YES**	**NO**
Have heart disease? (e.g. heart failure, high blood pressure)	**YES**	**NO**
Have type 1 or 2 diabetes?	**YES**	**NO**
Have chronic kidney and/or liver disease?	**YES**	**NO**
Have compromised immune system and are at risk of infection?	**YES**	**NO**
Have a neurological condition? (Parkinson's Disease, Motor Neurone Disease, Multiple Sclerosis or Cerebral Palsy)	**YES**	**NO**
Currently pregnant? How many weeks?	**YES**	**NO**
Client is high risk or vulnerable. As you are at high risk / vulnerable from Covid-19, I am unable to treat you at this time. Once shielding is reduced, please contact me to rebook your treatment.	**No symptoms:** Therapist treats Date: Initials:	

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Please advise:

Do you have any other medical condition which makes you a higher risk to the effects of Covid-19?	YES	NO
If yes, please give details:		
Have you travelled abroad in the last 14 days?	YES	NO
If yes, please give details:		
Are you an NHS front line worker?	YES	NO
Are you a Carer, either at home or in a Care Home?	YES	NO
Are you allergic to any cleaning fluids?	YES	NO
If yes, please give details:		
Do you consent to me informing NHS Scotland Test & Protect of your details if either you or I find out we are infected?	YES	NO
Signed: _____ Dated: _____		

Legal disclaimer:

I _____ *(client's name)* confirm:

- within the last 14 days, I have not been diagnosed with Covid-19, nor have I experienced any Covid-19 symptoms;
- to the best of my knowledge, within the last 14 days no member of my household has been diagnosed with Covid-19, nor have they experienced any Covid-19 symptoms;
- to the best of my knowledge, within the last 14 days neither myself nor any other member of my household have been exposed to anyone diagnosed with Covid-19 or experiencing Covid-19 symptoms.

By signing this document, I confirm the above statements are true and correct.

I hereby acknowledge that complementary services involve close contact with a Complementary Therapist for a period and in circumstances in which it is possible to contract Covid-19, notwithstanding any safety measures and precautions to the contrary. I agree to accept this risk in order to receive the benefit of the complementary services.

I hereby irrevocably and unconditionally waive all claims and release and forever discharge _____ *(Therapist's name / Clinic name)* and its officers, directors, and employees from all and any liability whatsoever in relation to any claim for any death, injury, loss, or damage of whatsoever nature, that may arise if I contract Coronavirus in the provision of the services or infect another person, except in so far as it can be demonstrated that such death or injury was occasioned as a result of _____'s *(Therapist's name / Clinic name)* negligence or failure to take appropriate safety measures and precautions. Nothing in this document excludes or limits any liability which cannot legally be limited, including but not limited to liability for death or personal injury caused by negligence.

Signed: _____ Dated: _____