COVID-19 Liability Release Waiver Form

BEAUTY CREATION
EWELINA SZYDŁOWSKA

Due to the 2019-2020 outbreak of the novel Coronavirus (COVID-19), our business is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfecting procedures in compliance with CDC guidance.

Full Name (in capitals) _____ **Date** _____

SYMPTOM WELLNESS CHECK

Have you ever experienced any of the following symptoms within the last 14 days?

Fever or feeling feverish, new cough, shortness of breath, flu-like symptoms such as fatigue, nausea, diarrhoea? Chills? Repeating shaking chills? Muscle pain? Headache? Sore throat? New loss of taste or smell? Rash.
Please circle all that apply

❑ YES ❑ NO

Have you been diagnosed or suspected of having Coronavirus or Covid-19? ❑ YES ❑ NO
If yes, when? _____

Have you been tested for Coronavirus or COVID-19? ❑ YES ❑ NO
If tested, was the testing performed by nasal swab or blood test? _____
If tested, did you test: Positive or Negative? _____

Have you had an antibody test for Coronavirus? ❑ YES ❑ NO
If tested, did you test: Positive or Negative? _____
If known, was the test for IgM or IgG antibody? _____

FAMILY AND CLOSE CONTACTS

Are you, or anyone you live with, in a “high-risk group”? ❑ YES ❑ NO

Have any of your family members or immediate/close contacts currently sick or experiencing fever, cough, shortness of breath, or flu-like symptoms (sore throat, muscle aches, fatigue, nausea and diarrhoea)? ❑ YES ❑ NO

Have any of your family members or immediate/close contacts been diagnosed with Coronavirus or COVID-19? ❑ YES ❑ NO

Have you been exposed to anyone who has had COVID-19 in the past 4 weeks? ❑ YES ❑ NO

RECENT TRAVEL

Have you travelled outside the UK in the past 14 days? ❑ YES ❑ NO
If yes, where have you been? _____

Have any of your family members travelled outside the UK in the past 14 days? ❑ YES ❑ NO
If yes, where have you been? _____

I understand that I am required to wear a face mask to my appointment	❑ YES	❑ NO
I understand COVID-19 virus has a long incubation period. Carriers may not show any symptoms of the virus but can still be highly contagious.	❑ YES	❑ NO
I knowingly consent to have a service at **Beauty Creation Ewelina Szydłowska** during the COVID-19 pandemic.	❑ YES	❑ NO
I understand that I will need to review, resign and date this form before every future appointment.	❑ YES	❑ NO
I understand **Beauty Creation Ewelina Szydłowska** has taken all necessary precautions to prevent the spread of COVID-19 and will not hold the salon liable for exposure of the virus.	❑ YES	❑ NO
I understand I will need to follow the salon guidelines to prevent the spread of COVID-19	❑ YES	❑ NO
I acknowledge that the information I have given is accurate and complete. I am happy to proceed with my treatment.	❑ YES	❑ NO

Client Signature _____ ***Client Date*** _____