Covid-19 screening form and consent

Full name

Today's date

	Y	N
1) Have you had a fever in the last 7 days? (feeling hot to touch on your chest and back)		
2) Do you now, or have you recently had, a persistent dry cough? (coughing a lot for more than an hour, 3 or more coughing episodes in 24 hours or worsening of a pre-existing cough)		
3) Do you have any other symptoms that may mean you have a COVID-19 infection? (Loss of taste and smell. unusual fatigue or shortness of breath)		
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?		
5) Have you been told to stay home, self-isolate or self-quarantine?		
6) Do you or anyone that you live with fall into the 'clinically vulnerable' or 'clinically extremely vulnerable' categories as defined here?		

Consent for treatment

I understand that, because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including Covid-19.

I can confirm I have made myself familiar with "What to expect" information leaflet.

I agree to let Lenka know any changes to my health / self-isolation occurred.

I give my consent to receive treatment from Lenka Antalova.

Name

Signed

Date

LA's signature

Date