



Hands On

Sports Therapy & Injury Clinic

Get Better, Be Better

Keeping COVID Safe

Date:

COVID-19 Client Screening and Consent Form

Full Name	
Address	
Post Code	
Date of Birth	
Telephone Number	
Email Address	

	Yes	No
I can confirm that I DO NOT currently have COVID-19 nor have I had it in the last 5-7 days. I do not currently have any COVID-19 symptoms (continuous cough, high temp, loss of taste or smell) and feel generally well.	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic have you contracted or think you may have contracted COVID-19?	<input type="radio"/>	<input type="radio"/>
If YES to the above, was this in the last 6 months?	<input type="radio"/>	<input type="radio"/>
If YES again, please answer a. b. & c.		
a. Can you exercise to get your heart rate and respiratory rate up without any problem?	<input type="radio"/>	<input type="radio"/>
b. Have you had a new onset of muscle aches and pain since the emergence of the virus?	<input type="radio"/>	<input type="radio"/>
c. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin?	<input type="radio"/>	<input type="radio"/>
Do you have any of the following health issues:		
High Blood Pressure or Heart Condition?	<input type="radio"/>	<input type="radio"/>
Diabetes Type I or II	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Lung Condition	<input type="radio"/>	<input type="radio"/>
If YES to any of the above please give further details		
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Declaration

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true.

I understand that Hands On Sports Therapy cannot be held liable should I experience exposure to the virus or any other contagion as a result of my providing misinformation on this form.

I understand that, because sports therapy treatment involves maintaining prolonged and close physical contact, there may be an elevated risk of disease transmission, including COVID-19.

I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

Signed..... **Date**.....