

**Health Information
COVID-19 Information & Liability Waiver**

Guest Name: _____

Date: _____

COVID-19 Information

1. Have you had a fever in the last 24 hours of 100 degrees or above? Yes No

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes No

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has Coronavirus-type symptoms? Yes No

Consent for Treatment

I understand that, because Salon & Spa Services involve maintained touch and physical proximity over an extended period of time, there may be an elevated risk of disease transmission including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved in receiving a service. I voluntarily agree to assume those risks, and I hold harmless the employees/business from any claims related thereto. I give my consent to receive services.

Guest Signature: _____ Date: _____

Parent or Guardian (for minor): _____ Date: _____