COVID-19 Screening Checklist for Clients

Name____**Date**_____________ **Time**____________

Purpose: Based on the US Center for Disease Control Guidelines, service providers, daily, are encouraged to screen all clients for signs of respiratory illness accompanied by fever.

Instructions: All clients entering S Day Spa & Salon's building must be asked the following questions below. / will maintain this record for 14 days from completion of this form and have this form available upon request from the Public Health Department.

☐ By checking this box, I pledge to provide only correct and truthful information when completing this screening.

1. Do you have any of the following respiratory symptoms?

   - New or worsening cough? ____Yes _____No
   - New or worsening shortness of breath? ____Yes _____No

2. Have you had a (temperature 100.4*F or greater within the last 14 days) ____Yes _____No

3. Are you feeling feverish? ____Yes _____No

4. Are you having chills? _____ Yes _____No

5. Have you been in a facility or home with confirmed COVID-19 by lab test within the last 14 days? ____YES ____NO

6. Have you been with persons with confirmed COVID-19 by lab test within the last 14 days? ___YES ____NO

~If YES to any, please call and cancel your appointment immediately.
~If NO to all, proceed to remaining statements.

If you answered NO to all questions you will be allowed entry to building.

Please be aware of the following protocols:

- You will immediately wash your hands for at least 20 seconds upon entry into the building
- Not to shake hands with, touch or hug others during your time in the building
- Not congregate in any space within the salon & spa

By signing the form below I am acknowledging the potential risk to contract the COVID-19 disease during services provided today and voluntarily agreed to accept services. You further agree and hereby release / Day Spa & Salon and its employees from any and all liability associated with your potential risk to contract NOVEL CORONAVIRUS (COVID-19).

* The person answering YES to any of the above questions is responsible for following-up with their primary care physician if needed.

Client's Full Name: (please print)____

Client's Signature ______________________________________Date___________________

Service Provider's Signature ______________________________________Date_________________