CLIENT PRESCREEN AND WAIVER

Hand & Stone is committed to the safety and well-being of our clients and our staff. In order to continue to keep everyone safe and healthy, please complete the following mandatory COVID-19 screening and waiver prior to your appointment.

Are you currently experiencing any of these symptoms?

Choose any/all that are new, worsening, and not related to other known causes or conditions you already have.

- ☐ Fever and/or chills *(Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher)*
- ☐ Cough or barking cough (croup) *(Continuous, more than usual, making a whistling noise when breathing (not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have))*
- ☐ Shortness of breath *(Out of breath, unable to breathe deeply (not related to asthma or other known causes or conditions you already have))*
- ☐ Sore throat *(Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have)*
- ☐ Difficulty swallowing *(Painful swallowing (not related to other known causes or conditions you already have))*
- ☐ Runny or stuffy/congested nose *(Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have)*
- ☐ Decrease or loss of taste or smell *(Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have)*
- ☐ Pink eye *(Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have))*
- ☐ Headache (*Unusual, long-lasting (not related to **getting a COVID-19 vaccine in the last 48 hours**, tension-type headaches, chronic migraines, or other known causes or conditions you already have))*
- ☐ Digestive issues like nausea/vomiting, diarrhea, stomach pain *(Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have)*
- ☐ Muscle aches/joint pain *(Unusual, long-lasting (not related to **getting a COVID-19 vaccine in the last 48 hours**, a sudden injury, fibromyalgia, or other known causes or conditions you already have))*
- ☐ Extreme tiredness *(Unusual, fatigue, lack of energy (not related to **getting a COVID-19 vaccine in the last 48 hours**, depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have))*
- ☐ Falling down often *(For older people)*
- ☐ None of the above

Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?

If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series), select "No."

If the person got a COVID-19 vaccine in the last 48 hours and is experiencing a mild headache, fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No."

☐ Yes ☐ No

HAND & STONE® MASSAGE AND FACIAL SPA

In the last 14 days, have you travelled outside of Canada? If exempt from federal quarantine requirements (for example, you are fully vaccinated and have met the specific conditions, or an essential worker who crosses the Canada-US border regularly for work), select "No."

☐ Yes ☐ No

In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19? If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series) and have not been told to self-isolate by public health, select "No."

☐ Yes ☐ No

Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)? This can be because of an outbreak or contact tracing.

☐ Yes ☐ No

In the last 10 days, have you tested positive on a rapid antigen test or home-based self-testing kit? If you have since tested negative on a lab-based PCR test, select "No."

☐ Yes ☐ No

In the last 14 days, have you received a COVID Alert exposure notification on your cell phone? If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series), select "No."

If you already went for a test and got a negative result, select "No."

☐ Yes ☐ No

I deem the benefits to my health of today's treatment outweigh the potential risks of exposure to COVID-19.

☐ I agree

_____ _____

Client Name (print name) Date

If this is being completed on behalf of a minor (_____) I certify that the above medical information is correct to the best of my knowledge. *Required*

☐ I agree Parent or Custodian of Minor (print name) _____