

## Client Informed Consent COVID-19

**Unless otherwise directed by the client's primary healthcare provider, clients at higher risk of severe illness from COVID-19 should forgo Rolfing and Somatic Exploration in-person sessions while the virus is present in their communities. While information is still limited, these underlying conditions place people at higher risk for severe illness from COVID-19:**

- › People 65 years or older
- › Chronic lung disease
- › Moderate to severe asthma
- › Heart conditions
- › Compromised or suppressed immunity
- › Severe obesity (body mass index of 40 or higher)
- › Diabetes
- › Chronic kidney disease
- › Liver disease

**Please answer the following questions and provide any details if necessary.**

› Have you been asked to self- isolate or quarantine by a doctor or a local public health official in the last 14 days?

☐ YES      ☐ NO

› Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)?

☐ YES      ☐ NO

› Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flu- like symptoms within the last 14 days?

☐ YES      ☐ NO

› Have you been tested for COVID-19? What type of test did you have? When were you tested?  
What was the result?

☐ YES☐ NO \_\_\_\_\_

› I understand that If I have any reason to suspect that I'm not completely healthy, I must postpone the session.

☐ YES☐ NO

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive Rolfing (Bodywork) sessions from this practitioner.

☐ YES☐ NO

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive Somatic Explorations (Embodied Counselling) from this practitioner.

☐ YES☐ NO

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

☐ YES☐ NO

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_