

**Tracy Cook Sports Therapy COVID-19 Treatment Consent Form**

Please read the following carefully; sign and date if you are in agreement and would like to commence treatment.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, knowingly and willingly consent to have face to face Soft Tissue Treatment completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

I confirm that I have not had any of the following symptoms of COVID-19 listed below within the last 21 days or knowingly been in contact with anyone with these symptoms:

• Fever (Temperature of above 37.9)

• Shortness of Breath

• Loss of Sense of Taste or Smell

• Dry Cough

• Runny Nose

• Sore Throat

\_\_\_\_\_\_\_\_ (Initial)

* I confirm that to the best of my knowledge, I have not been in close contact with anyone with confirmed COVID-19 in the last 14 days.
* I am confirm that I am happy to be treated by Tracy Cook Sports Therapy, who will also be wearing a mask.
* I confirm that I am wearing a clean face mask that fits well or wear a new one provided to me by my therapist.
* I confirm that I understand the Ned to wear a face mask for the duration of the session.
* I agree that I take full responsibility for attending and receiving treatment and willing to break 2m social distancing rule to receive treatment and instead will wear a clean face mask in order to maintain a low risk environment of passing on COVID-19 (as a possible unknown carrier)
* I acknowledge I have been made aware of the risks and new protocols put in place to keep the environment safe and that I have done everything in my control to abide by the new protocols to enable the environment to remain safe for others.
* I confirm that Tracy Cook Sports Therapy has taken necessary precautions or mitigated the risk to make the environment safe for me to receive treatment.
* If I am in the shielded group, I confirm that I have made Tracy Cook Sports Therapy aware and I have consulted with my doctor prior to receiving treatment.

\_\_\_\_\_\_\_\_ (Initial)

About my Visit:

I confirm I am aware of the requirement to be met outside by my therapist before entering where possible; this is to check for my wellness and face mask covering is adequate to keep myself safe.

I confirm I am aware of the requirement to use anti-bacterial hand sanitiser upon entering and when leaving premise.

I confirm I am aware that I am required to wear a face-covering whilst in therapy environment.

I confirm I have been told about the cleaning of the therapy room before/after my visit.

I confirm I am aware of the payment procedure requirements of paying by Bacs (account details will be given to me) and if I am paying cash it must be the exact money and be given to my therapist in an envelope to avoid contamination for both parties.

I understand that my therapist is required to wear a face mask during my appointment and this is not optional for them.

\_\_\_\_\_\_\_\_ (Initial)

About my Therapist:

They have confirmed they have not had any of the following symptoms in the last 14 days: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose or sore throat:

They have confirmed that to the best of their knowledge, they have not been in close contact with anyone with confirmed COVID-19 in the last 14 days.

I have had the opportunity to ask all the questions I wish to, and all of my questions have been answered to my satisfaction. Use space below to record questions you would like to ask:

\_\_\_\_\_\_\_\_\_\_ (Initial)

I agree to attend a face to face appointment during the COVID-19 pandemic.

\_\_\_\_\_\_\_\_\_\_\_ (Initial)

Signed Client ……………………………………………… **Date**: ………………………

OR  [delete as applicable]

Signature of person with parental responsibility / person legally entitled to sign on behalf of a person who lacks capacity

………………………………………………………………………………………………

Signed by Therapist…………………………………………………. Date: …………………………….