**Risk acknowledgement form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the safety of our clients and coworkers please answer the questions listed below:

Most common symptoms of COVID-19 include:

Fever, fatigue, dry cough, difficulty breathing

What is your Temperature on the day of your appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I affirm that I, nor any member of my household have had any of the symptoms listed above in the past 14 days.

YES NO (please circle one)

I affirm that I, as well as anyone in my household, have not been knowingly exposed to someone diagnosed with COVID-19 in the past 30 days. (please circle one)

YES NO

I affirm that I, as well as anyone in my household, have not been out of the country or province or to any area that is considered a “*hotspot*” for COVID-19 in the past 30 days. (please circle one.)

YES NO

I understand that Heidi Rofe at Beauty Starts Hair has implemented recommended disinfection protocols but that the risk of infection of COVID-19 still exists. I am I attending my appointment and I have knowledge of that risk. (Please circle one)

YES NO

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\* If you are unable to answer yes to all the questions above please reschedule your appointment

**THE SECTION BELOW IS VOLUNTARY**: If you are uncomfortable answering the questions below, it is **NOT REQUIRED** to attend your appointment. This information is completely **CONFIDENTIAL** and will not be shared with anyone.

I have receive the Covid-19 Vaccine YES NO

Date of: 1st Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_