



## Client COVID-19 Screening Questionnaire & Waiver

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Reflections is serious about protecting you and our employees from exposure to the COVID-19 virus. As a result, we have implemented various safety precautions. These steps were outlined in an attachment (Overview of COVID-19 Safety Actions) emailed to you with the confirmation of your appointment.

We also have certain expectations of you our valued client. These expectations are summarized in an attachment (Reflections Client Expectations) also emailed to you with the confirmation of your appointment.

Please ensure you carefully read the two documents noted above. You will be required to complete and sign this questionnaire & waiver at the time of your appointment. A blank copy of this form will be available in the vestibule.

Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

1. In the last 14 days have you or are you currently experiencing any of the following symptoms\*?

- Yes \_\_\_\_\_ No \_\_\_\_\_ (if YES circle all that apply)

Severe difficulty breathing	Feelings of confusion	New or worsening cough
Severe chest pain	Lost consciousness	Other: (specify)
Hard time waking up	Fever	
Runny Nose	Sore Throat	

*\*new symptoms or otherwise unexplained (e.g. not your usually seasonal allergies)*

2. In the last 14 days have you been tested for COVID-19?

- Yes \_\_\_\_\_ No \_\_\_\_\_ What was the result: \_\_\_\_\_

3. In the last 14 days has anyone in your household had symptoms or been tested for COVID-19?

- Yes \_\_\_\_\_ No \_\_\_\_\_ What was the result: \_\_\_\_\_

4. In the last 14 days, were you directed to self-isolate or quarantine by a medical professional?
  - Yes \_\_\_\_\_ No \_\_\_\_\_
5. In the last 14 days have you been exposed to the COVID19 virus? (That you are aware of)
  - Yes \_\_\_\_\_ No \_\_\_\_\_
6. In the last 14 days have you been outside Canada or encountered anyone who has travelled outside Canada? (That you know of or are aware of)
  - Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered Yes to any of the above questions, please provide more detail below.

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I certify that the above statements are true and understand if I falsify any of the above information, I could be putting other people at risk.

If any of the answers to the above questions change, or my status changes I will notify Reflections immediately; before reporting to my appointment.

I understand that Reflections Total Skin Care cannot be held liable should I experience exposure to the virus or any other contagion as a result of my providing misinformation on this form. I understand that, because spa services involve maintaining prolonged and close physical contact, there may be an elevated risk of disease transmission, including COVID-19.

By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive spa treatments from Reflections Total Skin Care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_