NAME: ________________________________

APPOINTMENT DATE(S): ____________________

REQUIRED FORM

The following information is required before your appointment. If you cannot complete this form, please arrive early to your appointment and our spa coordinator will provide you with a printed form to complete before your appointment. Your appointment may be shortened if this required form is not completed. All information is kept private and strickly confidencial. Thank you in advance for your understanding.

Are you experiencing any of the following symptoms (check all that apply):

- ☐ Fever/chills
- ☐ Cough
- ☐ Sore throat or hoarse voice
- ☐ Shortness of breath
- ☐ Loss of taste or smell
- ☐ Vomiting
- ☐ Diarrhea for more than 24 hours?
- ☐ None, I am not experiencing any of these symptoms

Are you experiencing two or more of any of the following symptoms:

- ☐ Runny nose
- ☐ Muscle aches
- ☐ Fatigue
- ☐ Pink eye
- ☐ Headache
- ☐ Skin rash of unknown cause
- ☐ Nausea
- ☐ Loss of appetite?
- ☐ None, I am not experiencing any of these symptoms

Have you been in contact in the last 14 days with someone that is confirmed to have COVID-19?

- ☐ YES
- ☐ NO

Have you had laboratory exposure while working directly with specimens known to contain COVID-19?

- ☐ YES
- ☐ NO

Have you been in a setting in the last 14 days that has been identified as a risk for acquiring COVID-19, such as on a flight, in a workplace with a cluster of cases or at an event without social distancing?

- ☐ YES
- ☐ NO

Have you travelled outside of Ontario in the last 14 days, excluding personal travel to border communities?

- ☐ YES
- ☐ NO