SÉRONA
Beauty & Laser Clinic
www.seronabeautylongford.ie

# COVID-19 CONSENT FORM

SERONA BEAUTY & LASER CLINIC

TREATMENT: ______________________ DATE: ______________

PLEASE TAKE A MOMENT TO COMPLETE OUR CONSENT FORM. BY SUBMITTING THE FORM BELOW YOU AGREE TO KNOWINGLY AND WILLINGLY CONSENTING TO HAVE HAIR/SKIN/BODY SERVICE DURING THE COVID-19 PANDEMIC.WE RESERVE THE RIGHT TO REFUSE SERVICE IF THIS FORM IS NOT SUBMITTED. THANK YOU.

## PERSONAL DETAILS

NAME: ______________________ DOB: _______ TELEPHONE: _________________

EMAIL ADDRESS: ________________________________________________________

ADDRESS: _______________________________________________________________

DOCTOR'S NAME: ________________________ TELEPHONE: _________________

## CONSULTATION QUESTIONNAIRE

I CONFIRM THAT I AM NOT PRESENTING ANY OF THE FOLLOWING SYMPTOMS OF COVID-19 LISTED BELOW:

- TEMPERATURE ABOVE 98.7 DEGREES F
- SHORTNESS OF BREATH
- LOSS OF SENSE OF TASTE OR SMELL
- DRY COUGH
- SORE THROAT Y/N ____________

I CONFIRM THAT I HAVE NOT BEEN IN CONTACT WITH ANYONE WITH THESE SYMPTOMS IN THE PAST 14 DAYS Y/N_________

I DO NOT LIVE WITH ANYONE WHO IS SICK OR QUARANTINED. Y/N ____

I VERIFY THAT I HAVE NOT TRAVELED OUTSIDE OF IRELAND IN THE PAST 14 DAYS TO COUNTRIES THAT HAVE BEEN AFFECTED BY COVID-19 Y/N ______

*CLIENTS SIGNATURE* ________________________________

*THERAPISTS SIGNATURE* ____________________________