Natural Health Practitioners of Canada
Praticiens de la Santé Naturelle du Canada

COVID-19 Waiver

Due to the COVID-19 pandemic, we are taking extra precautions with the intake of each client. Please answer these questions truthfully so we may continue to do our best to stop the spread.

Primary symptoms of COVID-19 may include:

- new cough or a chronic cough that is worsening
- fever
- new or worsening shortness of breath or difficulty breathing
- sore throat
- runny nose

Secondary symptoms of COVID-19 may include:

- stuffy nose
- painful swallowing
- headache
- chills
- muscle or joint pain
- gastrointestinal symptoms
- loss of sense of smell or taste
- conjunctivitis (pink eye)

If you are completing this form electronically, please type your name and date below, check the check box (if applicable), and use the Sign Document button to add an electronic signature.

I, _____, accept the following affirmations
(print your name)

when engaging in a treatment from _____:
(print your NHPC practitioner's name)

- I understand the above symptoms and affirm that I, as well as all members of my household, do not currently have nor have experienced COVID-19 symptoms within the last 14 days.
- I affirm that I, as well as all members of my household, have not been diagnosed with COVID-19 within the last 14 days.
- I affirm that, to my knowledge, in the last 14 days I have not been in contact with anyone who has been diagnosed with COVID-19.
- I affirm that **if** I travelled outside of Canada in the last month, I isolated in my home for 14 days upon my return.
- I understand that, because massage therapy and other natural health practices involve maintaining prolonged and close physical contact, there may be an elevated risk of disease transmission, including COVID-19.
- I understand that this business and my NHPC practitioner (identified above) 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.

☐ If a potential COVID-19 exposure occurs at this business, I consent to provide my name and contact information to Alberta Health Services for the purpose of contact tracing.

By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage therapy and bodywork.

Signature:_____ Date:_____