Covid-19 Consent Form

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| **Name** |  |
| Date of Birth |  |

Covid-19 Screening Information Y N

1. Do you now, or have you recently had, a persistent hacking, tickly or dry cough, without other cold symptoms? Coughing up phlegm or mucus, coughing a lot for more than an hour or 3 or more coughing episodes in 24 hours or a worsening of a pre-existing cough  
2. Have you had a fever or high temperature in the last 7 days with no other symptoms? (fever, feeling hot to touch on your chest and back, chills and shivering)  
3. Have you currently got any other cold or flu symptoms? Headache, aching muscles, a blocked or runny nose, sneezing, sore throat, pain in the face  
4. Do you have any other symptoms that may mean you have a Covid-19 infection? (loss of taste and smell, unusual fatigue or shortness of breath)  
5. Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?  
6. Have you been told to stay home, self-isolate or self-quarantine?  
7. Have you returned from travelling abroad in the last 14 days?  

*Sources:* [*https://111.nhs.uk/covid-19*](https://111.nhs.uk/covid-19) *and* [*https://www.gatewayworkshops.co.uk/MainUpload/COVID\_19\_Questionnaire\_\_Declaration\_form\_July\_1st\_2020.pdf*](https://www.gatewayworkshops.co.uk/MainUpload/COVID_19_Questionnaire__Declaration_form_July_1st_2020.pdf)

**Please note:** If you are experiencing difficulty breathing or chest pain you should seek medical help immediately. If you are experiencing and are worried about any of the other symptoms above you should cancel your appointment with your practitioner, call 111 and follow their guidelines.

We are obliged to notify NHS track and trace if circumstances require such. If I/We report any symptoms among staff or clients, or are contacted by Track and Trace, we are legally obliged to provide them with your contact details and you may be contacted.

**Help us protect others:**

We urge you to contact your therapist immediately if you or anyone in your household develops symptoms associated with COVID-19 within 7 days of your treatment

If anything changes between now and your appointment time, please inform your therapist before your appointment date

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| People at High Risk (Extremely Vulnerable) Y N |
| *Please tick YES if any of the following apply, You:*   |
| * Have had an organ transplant
* Are having chemotherapy or antibody treatment for cancer, including immunotherapy
* Are having an intense course of radiotherapy (radical radiotherapy) for lung cancer
* Are having targeted cancer treatments that can affect the immune system (such as protein kinase inhibitors or PARP inhibitors)
* Have blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma)
* Have had a bone marrow or stem cell transplant in the past 6 months, or still taking immunosuppressant medicine
* Have been told by a doctor that you have a severe lung condition (such as cystic fibrosis, severe asthma or severe COPD)
* Have a condition that means you have a very high risk of getting infections (such as SCID or sickle cell)
* Are taking medicine that makes you much more likely to get infections (such as high doses of steroids)
* Have a serious heart condition and are pregnant

If you select **Yes** after reading this list, the practitioner should explain that you are classed as clinically extremely vulnerable and the government advise that you exercise ‘shielding’ following current government advice.*Source:* [*https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/*](https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/) |

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| People at moderate risk (clinically vulnerable) Y N |
| *Please tick YES if any of the following apply to you. You:*   |
| * Are 70 or older
* Are Pregnant
* Have a lung condition that is not severe (such as asthma, COPD, emphysema or bronchitis)
* Have heart disease (such as heart failure)
* Have diabetes
* Have chronic kidney disease
* Have liver disease (such as hepatitis)
* Have a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy)
* Have a condition that means you have a high risk of getting infections
* Taking medicine that can affect the immune system (such as low doses of steroids)
* Very obese (BMI of 40 or above)

If you select **Yes** after reading this list, you are at moderate risk from coronavirus and it is very important you follow the advice on social distancing.*Source:* [*https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/*](https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/) |

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| Consent for the session |
| I declare that the information I have provided is correct to the best of my knowledge. I understand that, because my treatment may involve touch and close physical proximity, there may still be some risk of disease transmission, including Covid-19. I confirm that I have considered alternative options (not close contact) and have discussed all aspects of Infection Prevention Control (IPC) with my practitioner. I understand my practitioner is following government guidelines on IPC for close contact workers and their professional body’s code of conduct and advice. I have been informed about the variety of measures my practitioner is taking to minimize any risks for infection and I have been given enough information to be able to do my own risk assessment to decide whether or not to continue with the session. We conduct this session by mutual agreement, being aware of all potential risks, both parties acting to the best of our knowledge to minimize the risks of transmission. I consent to the practitioner retaining the details provided on this form for a period of 7 years from today. I further understand that if I am under 18 years of age, these records will be kept at least until I reach the age of 25 (7 years after reaching 18). |

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| Signature |  |
| Date |  |
| If signing for a child please give your name and relationship to the client |
| Name |  |
| Relationship |  |