ROSEDALE CLINIC CONSENT FORM.

COVID 19 . VIRAL AWARENESS.

NAME.....

SCREENING INFORMATION.

HAVE YOU HAD A FEVER IN THE LAST 7 DAYS ? YES / NO

DO YOU HAVE A PERSISTENT DRY COUGH ? YES / NO

IN THE LAST 14 DAYS, ANY CONTACT WITH A

COVID 19 DIAGNOSED PERSON ?.....YES / NO

HAVE YOU BEEN TOLD TO QUARANTINE,

OR SELF ISOLATE ?.....YES / NO

ANY OTHER VIRAL SYMPTOMS ? LOSS OF TASTE

/ SMELL ? SEVERE FATIGUE ? BREATHLESS ?.....YES / NO

CONSENT FOR TREATMENT;

I UNDERSTAND THAT BECAUSE MY TREATMENT MAY INVOLVE TOUCH AND CLOSE PROXIMITY, THERE MAYBE AN ELEVATED RISK OF DISEASE TRANSMISSION INC

COVID-19.

I GIVE MY CONSENT TO RECEIVE TREATMENT FROM

CHRIS BOARDMAN.

NAME.....DATE ....

SIGNED.....

IF POSSIBLE ,PLEASE PRINT, SIGN AT HOME AND BRING WITH YOU, OR SIGN HARD COPY AT THE ROSEDALE .

I WEAR A MASK TO PROTECT YOU. YOU MAY IF YOU WISH. THE CLINIC IS COVID-19 COMPLIANT.