

Amanda's Massage COVID-19 Screening Questions

Name of Client: _____ Date of Service: _____

1. Have you traveled outside of NH, CT, ME, VT, RI or MA in the last 14 days?

No _____ Yes* _____ ask follow-up question.

- a. Have you traveled internationally?

No _____ Yes _____

2. Have you had any UNPROTECTED close prolonged contact with anyone with suspected or confirmed COVID-19 in that last 14 days? **Please note that wearing a cloth face mask is NOT considered protection.**

No _____ Yes _____

3. Have you had a fever or chills in the past 24 hours without using fever reducing medicine?

No _____ Yes _____

4. Are you having any of the following symptoms?

- Shortness of breath, Muscle Aches, Cough, Sore Throat, Fatigue, Headache, Nausea, Vomiting, Diarrhea, Nasal Congestion, Runny Nose AND/OR Changes in your sense of taste or smell that is atypical for you.

No _____ Yes _____

5. Does the person currently have a fever?

- A fever is defined as a temperature above 100.0F or 37.8C

No _____ Yes _____

If YES to any question, the person shall NOT be permitted to enter the studio.

6. Have you been fully vaccinated?

- Fully vaccinated means 14 days post all required vaccinations to complete series.

No _____ Yes _____

Signature of Client: _____