# COVID-19 Screening Checklist for Clients

**Name_____Date_____ Time_____**

**Purpose:** Based on the US Center for Disease Control Guidelines, service providers, daily, are encouraged to screen all clients for signs of respiratory illness accompanied by fever.

**Instructions:** All clients entering Serenity Day Spa & Salon's building must be asked the following questions below. Serenity will maintain this record for 14 days from completion of this form and have this form available upon request from the Public Health Department.

☐ By checking this box, I pledge to provide only correct and truthful information when completing this screening.

1. Do you have any of the following respiratory symptoms?

   - New or worsening cough? ____Yes _____No
   - New or worsening shortness of breath? ____Yes _____No

2. Have you had a (temperature 100.4*F or greater within the last 14 days) ____Yes _____No

3. Are you feeling feverish? ____Yes _____No

4. Are you having chills? _____ Yes _____No

5. Have you been in a facility or home with confirmed COVID-19 by lab test within the last 14 days? ____YES ____NO

6. Have you been with persons with confirmed COVID-19 by lab test within the last 14 days? ___YES ____NO

~If YES to any, please call and cancel your appointment immediately.
~If NO to all, proceed to remaining statements.

**If you answered NO to all questions you will be allowed entry to building.**

**Please be aware of the following protocols:**

- You will immediately wash your hands for at least 20 seconds upon entry into the building
- Not to shake hands with, touch or hug others during your time in the building
- Not congregate in any space within the salon & spa

**By signing the form below I am acknowledging the potential risk to contract the COVID-19 disease during services provided today and voluntarily agreed to accept services. You further agree and hereby release Serenity Day Spa & Salon and its employees from any and all liability associated with your potential risk to contract NOVEL CORONAVIRUS (COVID-19).**

* The person answering YES to any of the above questions is responsible for following-up with their primary care physician if needed.

Client's Full Name: (please print)_____

Client's Signature _____Date_____

Service Provider's Signature _____Date_____