Salon Dominique Covid-19

Patient Screening Form

PATIENT NAME:_____D.O. B_____

1. Have you or a family member of your household traveled outside the United States in the last 14 days? ☐ Yes ☐ No

2. Have you or a member of your household travelled inside the United States in the last 14 days? ☐ Yes ☐ No

3. Have you or a member of your household been on a cruise ship in the last 14 days? ☐ Yes ☐ No

4. Have you recently attended any events with more than 10 individuals?

   ☐ Yes ☐ No

5. Have you or a member of your household recently visited a Nursing home?

   ☐ Yes ☐ No

6. Have you or a member of your household been in close contact with an individual known to have Covid-19? ☐ Yes ☐ No

7. Have you or a member of your household been required to self-quarantine?

   ☐ Yes ☐ No

8. Do you currently have- or have recently exhibited – any of the following symptoms? **(PLEASE CHECK ALL THAT APPLY)**

☐ Cough

☐ Shortness of Breath or Difficulty Breathing

☐ Fever

☐Chills

☐Repeated Shaking with Chills

☐Muscle Pain

☐Sore Throat

☐ Loss of Taste or Smell

☐ Discoloration on the Toes or Fingers

☐ Diarrhea, Vomiting, and/or Belly Pain

☐Conjunctivitis of the Eye

In affixing my signature below, I certify that the above responses and statements are true and accurate to the best of my knowledge.

I also agree to each above statement and release Salon Dominique and my Stylist from any and all liability for the unintentional exposure or harm due to COVID-19.

Salon Dominique and all the employees and Independent Stylists within the facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

I understand all the potential risks, including but not limited to, the potential short-term and long-term complications related to COVID-19, and, in consideration of such risk, I would like to proceed with my desired scheduled treatment/service.

Signature:_____

Date:_____

STAFF USE ONLY

☐ Temperature Check

By: _____(Initial)