COVID-19 Screening Checklist

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 Krimson Hair Studio must be asked the following questions below. Krimson 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 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 the salon.

Please be aware of the following protocols:

- You will immediately sanitize your hands upon entry into the building
- Not to shake hands with, touch or hug others during your time in the salon
- Not congregate in any space within the salon
- You will wear a mask at ALL times
- You will not bring children or pets to the salon
- You will not bring any other devices besides your phone into the salon

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 Krimson Hair Studio, all Stylists that rent space at Krimson Hair studio 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_____