



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 Studio Booseh Beauty and Dance building must be asked the following questions below. Studio Booseh LLC 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 the remaining statements. If you answered NO to all questions you will be allowed entry to the 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 congregating in any space within the Studio 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 Studio Booseh LLC/Souzan Mills and its employees from any and all liability associated with your potential risk to contract 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 _____

Provider's Signature

_____ Date _____