Beauty Mark

COVID-19 LIABILITY WAIVER

Please complete the following questionairre before your upcoming Beauty Mark appointment:

Have you had a cough or sore throat?	◯ YES	◯ NO
Have you had a fever or do you feel feverish?	◯ YES	◯ NO
Do you have shortness of breath?	◯ YES	◯ NO
Do you have a loss of taste or smell?	◯ YES	◯ NO
Have you been around anyone exhibiting any of these symptoms within the past 14 days?	◯ YES	◯ NO
Are you living with anyone who is sick or quarantined?	◯ YES	◯ NO
Have you been out of state in the last 14 days?	◯ YES	◯ NO

RESET FORM

CLIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE (if client is under 18) _____