Ambience Beauty Salon

Covid-19 Pre-Treatment screening Form

FULL NAME:

DATE OF BIRTH:

ADDRESS:

Please answer the following questions

Question	YES	NO
Have you come into close contact with someone who has Coronavirus (Covid-19) in the last 14 days?	☐	☐
Have you come into close contact with someone who has displayed any of the following symptoms: Fever, Chills, Cough, Sore Throat?	☐	☐
Within the last 14 days, have you experienced any of the following symptoms: Fever, Chills, Cough, Sore Throat, Shortness of Breath, Chest Pains, High Temperature, Loss of Taste or Smell?	☐	☐
Have you or a household member been told to, or are self-isolating within the last 14 days?	☐	☐
Have you been tested for Coronavirus (Covid-19)?	☐	☐
Have you been diagnosed as having Coronavirus (Covid-19)?	☐	☐
Have you been vaccinated for COVID-19? If yes, please specify 1st and booster.	1st ☐ booster ☐	

I understand and I have answered the questions above truthfully.

I have been asked by Ambience to sanitise my hands upon arrival at the salon and remove any gloves that have been worn outside.

I understand that Ambience are taking all the necessary precautions and wearing the appropriate PPE in order to carry out my treatment.

I understand that this form will be held with my confidential client card. To assist the NHS Test & Trace, details may be requested to be shared for this purpose only.

SIGNED: **DATE:**

THERAPIST:

We hope you enjoy your treatment. Thank you for following our new rules!

No changes					
Date:					
Signature:					