



COVID-19 PANDEMIC – SCREENING FORM

Client Name: _____

D.O.B.: _____

1. Have you been instructed to self-isolate or self-quarantine?
Yes No
2. During self-isolation or self-quarantine, have you developed any cold or flu like symptoms?
Yes No
3. Have you recently completed a 14-day self-isolation or self-quarantine period?
Yes No
4. Have you seen a medical practitioner recently for any issues related to cold or flu?
Yes No
5. In the last 14 days have you had a Covid-19 test?
Yes No **Results**
6. Have you or anyone in the house travelled outside of the country OR province in the last 14 days?
Yes No
7. Have you had contact or social interactions with someone who has travelled outside of the country in the last 14 days?
Yes No
8. Have you been in contact with a person known to have COVID-19 or who is experiencing symptoms similar to a cold or flu?
Yes No
9. Are you experiencing any of the following symptoms: **sore throat, cough, fever, difficulty breathing or shortness of breath, headaches, loss of taste, and/or loss of sense of smell?**
Yes No

By signing or typing your name below, you agree that this form is completed accurately to the best of your knowledge.

Print Name: _____

Date: _____

Signature: _____

CONSENT TO TREATMENT: COVID-19

All practitioners and staff at Oakville Sports Medicine Centre are following the guidelines outlined by the Government of Ontario and Public Health.

These include guidelines for:

- Cleaning and proper sanitization before and after all appointments
- The use of Personal Protective Equipment (PPE)
- Procedures to maintain social distancing and limiting the number of individuals allowed in the clinic at one time
- Minimizing items that are deemed non-essential
- Contactless payment options available

Despite the best efforts of Oakville Sports Medicine Centre, due to the frequency of visits of other patients, and the characteristics of COVID-19 and treatments offered, you may be at an elevated risk of contracting the virus simply by being at the clinic.

I hereby acknowledge that I have agreed to meet with Fred Corradini, Kieran Chu (**circle service provider name**) at the clinic for Osteopathic Manual Practice, Athletic Therapy (**circle the service that applies**) and I am aware of the following:

1. There is a risk that I could be exposed to severe acute respiratory syndrome coronavirus 2, the virus responsible for COVID-19 while attending at the clinic to receive services. I accept and acknowledge that I could be exposed to COVID-19 through the following means:
 - a. My physical presence at the clinic
 - b. My interactions with other clients who are present at the clinic at the time of my attendance
 - c. My interactions with the staff at the clinic; and
 - d. The physical touching of any equipment and surfaces at the clinic
2. While receiving services, the Service Provider may need to be physically closer to me than the recommended social distancing guidelines to assess and/or treat me.

I acknowledge that I have read and fully understand the risks as described above. By signing or typing my name below I consent, acknowledge and confirm that I am willing to accept these risks as a condition of attending Oakville Sports Medicine Centre.

Print Name: _____

Date: _____

Signature: _____