COVID-19 RISK INFORMED CONSENT

I ________________________________(your name) understand that I am opting for an elective skin care/facial treatment that is not urgent and is not medically necessary.
I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Laura Gaston Skin Care is closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this skin care/facial treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective skin care/facial treatment, and I give my express permission for Laura Gaston to proceed with the same.
I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.
I understand that possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.
I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment itself.
I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment.
I understand that Laura Gaston Skin Care reserves the right to decline treatment if I screen positive on the Laura Gaston Skin Care COVID-19 Screening Questionnaire.
I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Client Signature:_________________________________**Date**:_________________

COVID-19 SCREENING QUESTIONNAIRE

1. Do you have any of the following symptoms: Cough, shortness of breath or difficulty breathing, chills,
sore throat, muscle pain, headaches, or loss of taste and/or smell? ____**YES ____NO**

2. Have you had any of the above symptoms in the last 14 days? ____**YES ____NO**

3. Have you had a positive COVID-19 test in the last 30 days? ____**YES ____NO**

4. Have you had a fever of 100.4F or greater over the past 48 hours? ____**YES ____NO**

5. Have you been in contact with a sick individual or a person known or suspected to have COVID-19 in
the last 14 days? ____**YES ____NO**

6. In the last 14 days, have you worked in an environment without social distancing (at least 6 feet) and/or
without personal protective equipment? ____**YES ____NO**

7. Have you travelled in the last 14 days prior to this appointment? ____**YES ____NO**
a. If yes, where? ______________________________

Please call or text Laura Gaston at 619-300-7877 to reschedule your appointment if you have answered yes to questions 1-4.

I UNDERSTAND THAT LAURA GASTON SKIN CARE RESERVES THE RIGHT TO DECLINE TREATMENT IF I SCREEN POSITIVE TO ANY OF THE QUESTIONS ABOVE.

Patient Signature: ______________________________________Date: ________________