**A close up of a sign

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**Declaration of Health & Disclaimer prior to Hands-On Therapy**

***I hereby confirm that:***

* I am not knowingly experiencing any symptom of the Covid-19 Coronavirus illness such as a **dry cough, shortness of breath or difficulty breathing, new loss of taste or smell, high temperature, fever, chills, repeated shaking with chills, muscle pain, headache or sore throat.**
* I have **not knowingly been exposed to**, **or in close personal contact with** any person exhibiting any of the Covid-19 Coronavirus symptoms listed above, within the last 14 days.
* I am not living, or working closely with, **any person who has been diagnosed** with the Covid-19 Coronavirus within the last 14 days.
* I have not **travelled internationally** within the last 14 days.
* I have not travelled to an **increased infection rate area** within the UK during the last 14 days.
* I have not been part of a **mass-participation event** within the last 14 days.
* I have not been **tested or diagnosed** with Covid-19 Coronavirus **and not yet cleared as non-contagious** by UK public health authorities.
* I am **following all UK Government recommended guidelines** as much as possible and limiting my exposure to the Covid-19 Coronavirus as much as practicably possible.
* *I acknowledge that Achilles Healers Sports Therapy has* ***put in place all reasonably practicable measures*** *to reduce the spread of the Covid-19 Coronavirus.*
* *I also acknowledge that Achilles Healers Sports Therapy* ***cannot guarantee that I will not become infected*** *with the Covid-19 Coronavirus. I understand that the risk of becoming exposed to and/or infected by the Covid-19 Coronavirus may indirectly result from the actions, omissions, or negligence of myself and others, including, but not limited to, clinic staff, and other clinic clients and their families.*
* ***I voluntarily seek the services provided*** *by Achilles Healers Sports Therapy and acknowledge that I am increasing my risk to exposure to the Covid-19 Coronavirus. I acknowledge that* ***I must comply with all set procedures whilst in clinic*** *to reduce the spread of the virus whilst attending my appointment.*

***Signed:*** *(Signature):* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Name:*** *(Print Name):* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date:*** *(DD / MM / YYYY):* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***