CONSENT FOR CHIROPRACTIC TREATMENT DURING THE COVID-19 PANDEMIC

1.1 I, _____, knowingly and willingly consent for myself or for a minor _____, under my care, to receive elective Chiropractic or emergency Chiropractic treatment from Dr Adriaan (Aldo) Victor during the COVID-19 pandemic.

1.2 I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.

1.3 Chiropractic procedures/treatment take place with the patient in very close proximity to the practitioner. This potentially exposes the patient and the practitioner to the COVID-19 virus.

1.4 I understand that due to the frequency of visits of other Chiropractic patients, the characteristics of the virus, and the characteristics of Chiropractic practice, that I have an elevated risk of contracting the virus simply by being in a Chiropractic office. _____ (Initial)

1.5 I confirm I am seeking treatment for a condition that cannot be done effectively or practically via Telehealth technologies.

Screening questions (1.6-1.8):

1.6 I confirm that I am not presenting ANY of the following symptoms of COVID-19 listed below <u>in the past two weeks</u>:

- **1.6.1 Fever**
- **1.6.2 Shortness of Breath**
- **1.6.3 Dry Cough**
- **1.6.4 Runny Nose**
- **1.6.5 Sore Throat**
- **1.6.6. Diarrhoea**
- **1.6.7. Malaise**

1.7 I confirm that I have not come in contact with any person tested positive for COVID-19 in the past two weeks that I know of.

1.8 High risk patients relating to the severity of COVID-19 are persons over the age of 60 and persons who have pre-existing medical conditions such as: asthma, chronic lung conditions, hypertension, autoimmune diseases, organ transplants, cancer, Immunocompromised, Obesity (BMI over 40) and Liver or kidney conditions. I confirm that I do not fall into any of these high risk categories.

1.9 In person consultations and treatment will only be done for high risk patients if absolutely necessary and in emergencies.

1.10 I am aware of the risks involved with the spread of COVID-19 and the risks it may hold to my health and the health of others I come in contact with. I accept those risks and hereby indemnify and hold the practitioner and his/her staff blameless should I contract the disease at the offices of the practitioner or from the practitioner or his/her staff members.

_____ _____

Patient's Signature (Parent/Guardian) DATE

PRACTICAL GUIDELINES TO THE CONSULTATION:

1.1 I, _____ have read and understand the practical guidelines as set out hereunder and confirm that I will comply thereto and prepare accordingly.

1.1.1 I will read the consent form (CONSENT FOR CHIROPRACTIC TREATMENT DURING THE COVID-19 PANDEMIC) with the screening questions (1.6 – 1.8 of the CONSENT FOR CHIROPRACTIC TREATMENT DURING THE COVID-19 PANDEMIC concent form) regarding COVID-19 which will be emailed to me and I will respond to the email to confirm that I have read the concent form with the screening questions before the chiropractic consultation, failing which I will not be treated.

1.1.2 Patients will be stopped from entering the practice if the patient hasn't complied with proper control measures.

1.1.3 Patients will be on time for their appointments to minimize contact between patient consultations, otherwise not be allowed in the waiting room and will be requested to wait in their cars until called by the practitioner or a staff member to enter the practice.

1.1.4 All patients will be sprayed with hand sanitiser upon entry.

1.1.5 All patients must wear a face mask.

1.1.6 On arrival, patients will again be screened for risk factors including screening questions and possibly the taking of temperature.

1.1.7 Between consultations, the necessary hygiene/cleaning protocols will be done by the practitioner and/or their staff compliment and this may cause a delay and prolong waiting periods.

1.1.8 Patients are requested to avoid touching anything inside the practice.

1.1.9 Patients are requested to remove any jewellery and leave same at home as it can be carriers of infections droplets.

_____ _____

Patient's Signature (Parent/Guardian) DATE