

*CONSENT TO RECEIVE MASSAGE*

*I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner.*

\_\_\_\_\_  
*Client Print Name*

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Therapist Print Name*

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date