Amaryllis
THERAPY NETWORK

Consent for Treatment During COVID

By initialing all items below, you agree that you have read and acknowledge that:

_____ I am aware of the health risks of COVID-19 and elect to continue treatment of my infant/child despite the potential risk of exposure to myself and my infant/child.

_____ I understand that the distancing guidelines between my infant/child, myself and the therapy provider will not be feasible in order to treat my infant/child.

_____ I agree to wear a mouth and nose covering at all times while in the clinic.

_____ I agree to follow Amaryllis Therapy Network's health and safety protocol which currently includes:

- Parents and children are required to wait in their vehicle until their appointment time. We are not allowing any visitors to your child's appointment at this time.
- If anyone in your home has a cough or a temperature higher than 100.4 degrees but your child is healthy, we kindly ask that you reschedule your child's appointment as a telehealth session.
- All infants, children and family members must have their temperature taken and participate in a symptom check before their appointment.
- Parents and children must wash their hands or use hand sanitizer before entering the clinic.
- Please cancel your child's appointment if anyone in your household is sick or is showing symptoms of COVID-19.

Authorization

By signing below, I agree to not visit the clinic for my child's appointment if I have been in close contact with a person who has tested positive or am showing symptoms of COVID-19. I confirm that I have read the above statements and agree to all terms and conditions contained herein.

Child's Name: _____
(Please Print)

Parent/Guardian's Name: _____
(Please Print)

_____ _____
Parent/Guardian's Signature Date