Blue Sky Therapeutics, LLC
240 Highland Dr.
Park City, UT 84098

COVID Consent Form

	Yes	No
1. Do you or your child have/had in the past 2 weeks:		
a. Fever, chills, or feel feverish	_____	_____
b. Shortness of breath or trouble breathing	_____	_____
c. A cough	_____	_____
d. Runny nose	_____	_____
e. Sore throat, headache	_____	_____
f. Reduced sense of taste or smell	_____	_____

2. Have you, your child, or family members, been with anyone who has had the above listed symptoms, or tested positive for COVID 19 in the past 2 weeks? Y_____ N_____

3. Have you, your child, or family members, tested positive for COVID 19 in the last 2 weeks? Y_____ N_____

4. Are you or any of your household members actively quarantining due to their possible exposure to COVID 19? Y_____ N_____

I understand that Blue Sky Therapeutics, LLC is following CDC guidelines to wear masks when possible and when social distancing is not possible. I understand that my child may not be able to keep a mask on his or her face during sessions. I consent to occupational therapy services by Blue Sky Therapeutics and assume any risks associated with this type of intervention.

To the best of my knowledge: I, my child, or family members, are not carriers of, nor infected with COVID 19. I agree to notify Jessica Kahn, MS, OTR/L within the next 5 days if symptoms occur with myself, my child, or a family member.

Parent Signature_____

Child's Name_____

Date_____