COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: _____ DOB: _____ Date: _____

Please read the following statements and initial next to each one to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last thirty (30) days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside the state in the last thirty (30) days.

I have answered the health questions above honestly and to the best of my knowledge. I understand that Family Vision Clinic, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

My signature below signifies that I agree that I will not hold Family Vision Clinic or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positive or presumptively positive with a COVID-19 diagnosis. There are certain inherent risks associated with an eye exam and eye care visit during a pandemic and I assume full responsibility for personal illness, injury, loss or damage arising out of my visit. I understand that COVID-19 infections can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye care to be essential to the maintenance of my vision.

_____ _____ _____

Print name of self or responsible party **Signature** **Date**