Vision Health Specialties
DOCTORS OF OPTOMETRY GRIGSBY SHEETS COOK

COVID-19 Self Declaration

Name (print please): *First:*_____ *Last:*_____

Residence: *City:*_____State:_____

Employer:_____

1. Are you currently, or have you in the last 24 hours, experienced any of the following symptoms: Temperature over 100.0 degrees, cough, shortness of breath, chills, muscle pain/aches, headache, sore throat, loss of taste or smell, or diarrhea?

   ( ) Yes

   ( ) No

2. Within the last 14 days have you lived with, cared for, or been in close contact with any individual that.....

   a. *Has a confirmed diagnosis of COVID-19?* ( ) Yes ( ) No

   b. *Is under self-quarantine regulations as instructed by a health care provider?* ( ) Yes ( ) No

   c. *Been in contact with bodily fluids of any individual with a diagnosis or who is under self-quarantine for COVID-19?* ( ) Yes ( ) No

   d. *Been within 6 feet of any individual with a diagnosis or under self-quarantine for COVID-19?* ( ) Yes ( ) No

3. Within the last 14 days have you been to New York City, New Orleans, Detroit, or Seattle?

   ( ) Yes ( ) No

4. Within the last 14 days have you traveled outside the United States?

   ( ) Yes ( ) No

Signature: _____ Date: _____ Temperature: _____