COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name:_____ Date:_____

Please read and initial next to the following statements. If you cannot positively affirm to all of these questions you will be asked to postpone your appointment to a later date.

_____ **Initial** I do not currently, nor have had in the last two weeks a fever, cough, chills, unexplained muscle pain, unexplained fatigue, shortness of breath, loss of taste or smell.

_____ **Initial** To the best of my knowledge, I do not have, nor have been in direct contact with someone who has confirmed diagnosis of COVID-19, nor been around anyone experiencing symptoms as described above.

_____ **Initial** Neither I, nor anyone living in my immediate household have traveled outside of the state in the last 30 days.

By signing this form, I agree that I will not hold Bright Side Eye Care or any of its doctor or staff personally responsible should I, or someone I come in contact with, become positive or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge Bright Side Eye Care and its doctor and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

Signature: _____

For Office Use Only

TEMPERATURE:	O2 READING:
_____	_____%