Office Use Only
Temp: _____

COVID-19 Screening & Consent to Treatment Form

We are dedicated to providing eye care to our patients in a safe environment while helping to prevent the spread of coronavirus (COVID-19) and the flu in our communities. In order to do this, it is important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

If any **ONE** of the following pertains to you:

- If you have a fever or above normal temperature
- If you are taking fever reducing medication
- If you have a cough
- If you are experiencing shortness of breath or having trouble breathing
- If you are experiencing reduction or loss of your sense of smell and/or taste
- If you have been in contact with someone who has tested positive for COVID-19 or suspected of having COVID-19
- If you have tested positive for COVID-19 (If yes, please provide test date and doctor's instructions:_____)
- If you are under doctor's orders to quarantine or self-isolate
- If you have been tested for COVID-19 and are awaiting results
- If you have traveled by air, bus, or train within the past 14 days

We respectfully ask that you let the staff know if any of the above pertains to you and they will reschedule your appointment for the safety of our patients, staff, and doctors. Thank you for your understanding.

I have read and acknowledge the above information and my signature below certifies that I am in good health and none of the above pertains to me.

COVID-19 is highly contagious and has a long incubation period. You or anyone who is in our office may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other patients and the characteristics of the virus, there is an elevated risk of you contracting the virus simply by being in our office.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

I acknowledge that I have read the above information and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment at this office during the pandemic.

_____ _____

Printed Name of Patient/Parent/Guardian Date

_____ _____

Signature of Patient/Parent/Guardian Date