COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: ________________________ DOB: ___________ Today's Date: ___________

Please read the following statements and initial next to the following statements 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 30 (thirty) days.

_________________________	___________________________	_________________
PRINT LEGAL NAME	SIGNATURE	DATE