Staarmann Family Vision Center, Inc.

COVID-19
Pandemic Essential Eye Exam
and
Treatment Consent Form

Patient Name:_____ **DOB:**_____ **Date:**_____

In an effort to maintain a safe environment for patients, doctors, and staff, please initial each of the following statements indicating your agreement:

_____ **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 confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.**

I have answered the health questions above honestly and to the best of my knowledge. I understand that Staarmann Family Vision Center, Inc. (doctors and staff) are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I am also aware that there is no definitive way to eliminate potential exposure by 100%.

By signing this form below, I agree that I will not hold Staarmann Family Vision Center, Inc. or any of its doctors or staff personally responsible should I, or someone I come in contact with become positive or presumptively 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. I further release and discharge Staarmann Family Vision Center, Inc. and its doctors 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.

_____	_____	_____
Print Legal Name	**Signature**	**Date**