

CORONAVIRUS ATTESTATION & TREATMENT CONSENT

Fullerton Eyes Optometry is committed to the health of our community. With the recent outbreak of Coronavirus we are taking extra measures to protect the health of our patients and employees. Please note that your doctor and staff may wear masks and gloves and may not shake your hand to minimize potential spread of infections.

Patient Attestation Statements

Note: If you cannot positively affirm NO to all these questions,
you may be asked to postpone or reschedule your visit to a later date.

1. Have you had in the last 14 days, a fever, cough, sore throat, loss of smell/taste or other cold symptoms? Yes No
2. To the best of your knowledge, have you 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? Yes No
3. Have you, or anyone living in your immediate household traveled outside of the state in the last 30 days? Yes No

I have read the above and have answered the health questions above honestly and to the best of my knowledge. I understand that Fullerton Eyes Optometry, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form I agree that I will not hold Fullerton Eyes Optometry or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Fullerton Eyes Optometry 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. I knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my visit and I consent to medical treatment.

Printed Patient Name

Date of Birth

Signature of patient (if over 18) or patient's parent or legal guardian

Date

If signed by parent/legal guardian, print name

Relationship