



COVID-19 PANDEMIC EYE EXAM AND EYECARE TREATMENT FORM

PATIENT NAME _____ (Parent if applicable) _____

DOB: _____ TODAYS DATE _____

*Please read the following statements and initial next to the following statements to indicate your agreement. If you cannot positively affirm ALL of these questions, you and your family will be asked to postpone all eyecare for a later date.

___ I , nor anyone in my immediate family/household, have not had a fever, cough, sore throat, loss of taste/smell or other cold symptoms in the last 2 weeks

___(To the best of my knowledge) I do not have, nor have I been in direct contact with someone who has confirmed a diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days

-NEW protocol for patient protection by Hudson Optical to ensure we are COVID-19 patient care compliant

-Spacing out exam times so fewer patient to doctor contact and patient to patient contact

-All staff is masked and our temperature checked every morning

-Number of patients in our office is now limited- once we reach that limit we will lock our door and service patients curbside

-For all at RISK patients we will isolate them in our office and lock the door to ensure their safety

-All equipment and tables and office furniture is now cleaned multiple times a day including immediately after seeing a patient

By signing this form below, I agree that I will not hold Hudson Optical or its doctors or staff responsible should I test positive or presumptively positively diagnosed or show signs of the COVID-19 virus. There are certain inherent risks associated with eye exams and eyecare during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge Hudson Optical and its staff and doctors for injury, loss, or damage arising out of my visit. I understand that the COVID-19 virus can lead to illness, disability, or ever death and I knowingly take the risk of exposure as I deem my eye exam and eyecare to be essential to the maintenance of my vision.

(print legal name)

(signature)

(date)