Vision Source™
Martin Eye Associates OD PA

COVID-19 Treatment Consent Form

I, (PRINT NAME)_____, consent to receive treatment from Martin Eye Associates, OD PA during the COVID-19 outbreak.

- I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.
- I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts.
- I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period or by having direct contact with infectious secretions from someone with COVID-19.
- I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

- I understand that the symptoms listed below are representative of COVID-19:
  - ➢ Fever / Temperature
  - ➢ Cough
  - ➢ Chills
  - ➢ Shortness of breath or difficulty breathing
  - ➢ Muscle pain
  - ➢ Pressure in the chest
  - ➢ Sore throat
  - ➢ Acute loss of smell or taste
- I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above.
- I confirm that I have not been previous diagnosed with COVID 19. If so, I confirm that a medical professional has cleared me to resume normal contact and it has been 21 days since being diagnosed.
- I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing, and monitor their health after their arrival.
- I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days.

- I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.

Patient Name (PRINT):_____

Patient/Guardian Signature:_____DATE:_____

MEA Employee Witness:_____DATE:_____

Patient Group Number per MEA screening (Circle One): 1 2 3 4