avant OPTOMETRY

Screening for COVID-19

Please initial next to the following statements to indicate your agreement. If you cannot positively affirm to all of these questions, you will be asked to reschedule your visit to a later date.

_____I do not currently have, or had in the last two weeks, a cough, difficulty breathing, fever, sore throat, chills, headache, or new loss of smell or taste.

_____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 days.

COVID-19 Informed Consent

Due to the COVID-19 pandemic, Avant Optometry is following the advice and recommendations from federal, state, and local authorities to implement new health policies and procedures to help prevent the spread of the coronavirus. Most importantly, we are screening all employees and patients before they enter the office to ensure that no one is currently exhibiting any of the known symptoms of COVID-19.

An individual can have COVID-19 but not have any symptoms. However, that person is still capable of spreading the virus to others without even knowing it. Knowing this information and the new precautions being made at this location, I choose to continue with my visit to Avant Optometry and I hereby acknowledge that there is no guarantee of a virus-free environment and assume the risk of becoming infected with COVID-19.

I affirm that I am over the age of 18 and am freely signing this consent form, or that I have the legal authority to sign on the child's behalf.

Date: _____

Patient Name: _____

Guardian Name/Relationship: _____

Signature: _____