COVID-19 Emergency Treatment Consent Form

I, _____ (the patient), consent to receive emergency treatment from Frisco In Focus during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19, including how it spreads and is 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 of time or by having direct contact with infection 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, 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 CDC (Center for Disease Control) and the AOA (American Optometric Association) guidelines do not recommend proceeding with any treatment that is non-essential at this time.

I understand that the treatment I am receiving is an emergency because of an underlying infection, pain, or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria. _____(Initial)

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: _____(Initial)

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. _____ (Initial)

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. _____ (Initial)

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

For Practice Use:

Doctor Signature: _____ Date: _____