DATE: ______________________

Patient(s) : ____

I, ___________*(Print Name)*____________________**verify that to the best of my knowledge, myself and other members of my family have not been tested in the last 14 days or going to be tested for symptoms of Covid-19. Also, to the best of my knowledge, I and members of my family have not been in contact with those that have been or going to be tested for symptoms of Covid-19.**

I (as stated above), verify that I will inform this office should testing of Covid-19 symptoms occur for myself and any members of my family within 14 days before and after visit to Precision Eye Care

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(Patient, Parent or guardian signature)