COVID-19 PANDEMIC EMERGENCY
DENTAL TREATMENT CONSENT FORM

PATIENT NAME: ___________________________________ **TEMPERATURE**___________

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that the dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus ______ (**initial**).

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus simply be being in a dental office _____ (**initial**).

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by Provincial Health Services:

- Fever > 38 deg. C ______ (**intial**).
- Cough ______ (**initial**).
- Sore Throat ______ (**initial**)
- Shortness of breath _____ (**initial**).
- Flu-like symptoms _____ (**initial**).
- Loss of smell _____ (**initial**).
- Loss of taste _____ (**initial**).

I confirm that I am not currently positive for the novel coronavirus. _____ (**initial**)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. _____ (**initial**)

I verify that I have not returned to the British Columbia from any country outside of Canada whether by car, air, bus, or train in the past 14 days. _____ (**initial**)

I understand that any travel from any country outside of Canada, including travel by car, air, bus, or train, significantly require self-isolation fir 14 days from the date a person has returned to Canada. ______ (**initial**)

I understand that the Provincial Health Services has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. _____ (**initial**)

I verify that I have not been identified as a contact of someone who has tested for novel coronavirusir been asked to self-isolate by Provincial Health, the Communicable Disease Control nor any other government health agency. _____ (**initial**).

Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders
I verify the information that I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed emergency dental treatment completed during the COVID-19 pandemic

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SIGNATURE OF PATIENT

PRINTED NAME ______________________________________ DATE _______________________