COVID -19 Treatment Consent Form

I, _____ (name of parent/guardian), consent for my child,

_____ (name of patient) to receive treatment from Pediatric Dental Care 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 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 my child and I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that under the CDC and ADA guidelines, they do not recommend proceeding with any treatment that is non-essential at this time.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry cough
- Shortness of breath
- High temperature
- Persistent pain or pressure in the chest
- Bluish lips or face
- New confusion or inability to arouse
- Sore throat
- Chills
- Loss of taste or smell
- Muscle pain
- Headache

I understand that my child and 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 my child and I have not traveled to any of the countries to 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 my child and I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____ (initial)

Patient Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____