AJL DENTISTRY

COVID-19 Pandemic Dental Treatment Consent Form

Patient name:_____

CMOH Order 05-2020 legally obligates any person who has the following core symptoms of cough, fever, shortness of breath, runny nose, or sore throat (that is not related to a pre-existing illness or health condition) to be in isolation (quarantine) for 5 days from the start of symptoms, or until symptoms resolve, whichever takes longer, or they receive a negative COVID Test. If they are exhibiting any of these symptoms, it is suggested they complete the COVID-19 Self-Assessment online tool to determine if they should be tested.

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

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. _____ (Initial)

I confirm that to my knowledge I am not currently positive for the novel coronavirus. _____ (Initial)

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

For Patients over 18, I confirm that I am not presenting any of the following core symptoms of COVID-19 as identified by AHS: :

- Fever > 38°C Recorded Temperature: _____

  Cough, Sore throat, Shortness of breath, Runny Nose _____ (Initial)

For patients under 18, I confirm that they are not presenting any of the following core symptoms of COVID-19 as identified by AHS:

- Fever > 38°C Recorded Temperature: _____

  Cough, Loss of sense of taste or smell, Shortness of breath _____ (Initial)

I confirm that I have followed federal government guidelines for testing and isolating after travelling outside of Canada. _____ (Initial)

I understand that Alberta Health Services has asked individuals to maintain physical 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 positive for novel coronavirus or been asked to self-isolate by AHS, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

I verify that I am a healthcare worker who has worn appropriate PPE. _____ (Initial)

_____

LIST of DENTAL TREATMENT

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19 pandemic.

_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN

Printed Name_____ Date_____

Feb 17, 2022