COVID-19 Pandemic Screening & Dental Treatment Consent Form

Patient name: _____

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

- Fever > 38°C _____ (Initial)
  Recorded Temperature: _____ °C
- Cough _____ (Initial)
- Loss of sense of taste or smell _____ (Initial)
- Shortness of breath _____ (Initial)

For Guardian/Caregiver accompanying the patient, I confirm that I am not presenting any of the following core symptoms of COVID-19 as identified by Alberta Health Services:

- Fever > 38°C _____ (Initial)
  Recorded Temperature: _____ °C
- Cough _____ (Initial)
- Shortness of breath _____ (Initial)
- Runny Nose _____ (Initial)
- Sore throat _____ (Initial)
- Loss of taste or smell _____ (Initial)

I confirm that to my knowledge that the patient, and I as Guardian/Caregiver, are not currently positive for COVID-19.
_____ (Initial)

I confirm that the patient, and I as a Guardian/Caregiver, are not waiting for results of a laboratory test for COVID-19.
_____ (Initial)

I confirm that the patient, and I as a Guardian/Caregiver, have not been a close contact of, or live with someone, who has tested positive for COVID-19 within the last 14 days. _____ (Initial)

I verify that the patient, and I as a Guardian/Caregiver, have not returned to Alberta from any country outside of Canada whether by car, air, bus, boat or train, within the last 14 days, and we have followed the Federal border measures and quarantine law in effect.
_____ (Initial)

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

_____
SIGNATURE OF GUARDIAN/CAREGIVER

Printed Name_____ Date_____

Updated December 1, 2021