COVID-19 Pandemic Screening & Dental Treatment Consent Form

Patient name: _____

Ora Dental is a healthcare facility with many dental procedures generating aerosols, and we have several patients who may be at more risk due to their age or compromised health.

I understand that despite the removal of most public health measures for COVID-19, Ora Dental will continue to require screening, masks and social distancing in order to keep all our staff and patients safe by preventing the spread of COVID-19 and other respiratory illnesses. _____ (Initial)

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 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)

CMOH Order *02-2022* legally obligates any person who has the following core symptoms of cough, fever, shortness of breath, loss of taste or smell, runny nose, or sore throat (that is not related to a pre-existing illness or health condition), or tests positive for COVID-19, to be in isolation for 5 days (fully vaccinated) / 10 days (not fully vaccinated) from the start of symptoms, or until symptoms resolve, whichever takes longer; for fully vaccinated, following isolation, wear a mask at all times when around others outside of home for up to 5 more days. If symptomatic but testing negative for COVID-19 should still home and away from others until symptoms resolve.

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

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

I confirm that the patient, and I as a 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 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. _____ (initial)

_____

SIGNATURE OF GUARDIAN/CAREGIVER

Printed Name_____ Date_____

Updated April 1, 2022