<u>COVID-19 Pandemic Minor Dental Treatment Consent Form</u>

I, _________________________________, knowingly and willingly consent to let my child, _________________________, have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

While our office complies with the CDC infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Dental procedures create water spray. It is unclear how long the ultra-fine nature of the spray may linger in the air, which can transmit COVID-19 virus.

All patients/escorts are required to wear masks in our office. Fabric masks are ok.

Our staff are symptom-free and, to the best of our knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you some "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

<u>Please circle your answer to the following questions:</u>

1. Do you have a fever, or have you felt hot or feverish in last 14-21 days? YES NO
2. Are you having shortness of breath or other difficulties breathing? YES NO
3. Do you have a cough or dry cough? YES NO
4. Do you have a runny nose? YES NO
5. Do you have a sore throat? YES NO
6. Do you have sneezing, watery eyes, and or sinus pain/pressure that is unusual and not related to seasonal allergies? YES NO
7. Any other flu-like symptoms, such as GI upset, headache or fatigue? YES NO
8. Have you recently experienced a recent loss of taste or smell? YES NO
9. Have you been in contact with any confirmed COVID-19 positive patients? YES NO
10. Are you currently awaiting the results of a COVID-19 test? YES NO
11. Do you have heart disease, lung disease, kidney disease, diabetes or any other auto-immune disorders? YES NO
12. Have you traveled in past 14 days out of the Lakes Region? YES NO
13. If so, where did you travel?_________________________________

Signature of Parent_________________________________ Date_____________________________