edgemont
dental care

COVID-19 Screening and Consent

Temp <37.5°C: ____

Patient Name: _____ **Date:** _____

Screening

I confirm that:

- I am not currently positive or being tested for COVID-19. _____ (Initial)
- I have not been in contact with someone who has tested positive for COVID-19.
- I have not been asked to self-isolate.

I confirm that I have not had any of the following symptoms within the past 14 days (if yes, please circle):

- Dry cough
- Sore throat
- Shortness of breath
- Headache
- Fever (> 37.5 °C) _____ (Initial)
- Runny nose
- Post-nasal drip
- Loss of taste/smell

I confirm that I have not travelled outside of British Columbia within the last 14 days. _____ (Initial)

I confirm that my workplace is not considered high risk? (e.g. hospitals, care-home, etc.) _____ (Initial)

Consent

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

I understand that BC's Provincial Health Officer has advised physical distancing of at least six feet and it is not possible to maintain this distance and receive dental treatment. _____ (Initial)

I confirm that I do not have the following condition, including: serious cardiovascular disease (heart attack, stroke), serious respiratory disease (moderate/severe asthma, COPD, etc.), uncontrolled diabetes, immunocompromised conditions, kidney disease, liver disease, OR over age 70. _____ (Initial)

I certify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to proceed with dental treatment during the COVID-19 pandemic. _____ (Initial)

_____

Patient, Parent or Guardian Name (Signature)

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