ST JOHNS
PEDIATRIC DENTISTRY

Patient name:_____
Date:_____

COVID-19 Screening and Consent Form for Dental Treatment

You are receiving dental care during/following the events of the COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of dentists, patients and staff. We are taking precautions to limit the spread of the disease, yet there is still a possibility of transmission.

In regard to the past 2 weeks:

Have you/your family member had any symptoms of a fever (above 100.4◦F), shortness of breath or dry cough?

☐ Yes ☐ No

Have you/your family member been treated for any flu-like illness?

☐ Yes ☐ No

Have you/your family member traveled to any regions affected by COVID-19?

☐ Yes ☐ No

Have you/your family member been in contact with any confirmed COVID-19 positive person?

☐ Yes ☐ No

Have you been practicing social distancing?

☐ Yes ☐ No

By signing this document, you acknowledge that the answers provided above are true and accurate.

You fully understand and acknowledge the risks and precautions being taken at this time. You understand a compromised or weakened immune system can place you at greater risk for contracting COVID-19 and have disclosed all necessary information to your provider. You may be asked to consider rescheduling treatment after discussing any of this information with the provider.

Parent/Guardian Signature: _____