COVID-19: Screening and Consent

Patient's Information					Guardian's Information				
First Name					First Name				
Last Name					Last Name				
Temperature (°C)					Temperature (°C)				
Pre-Examination Protocol (Y/N)									
Fever		Yes		No	Fever		Yes		No
Cough or Sore Throat		Yes		No	Cough or Sore Throat		Yes		No
Loss of taste or smell		Yes		No	Loss of taste or smell		Yes		No
Shortness of Breath		Yes		No	Shortness of Breath		Yes		No
Muscle Pain		Yes		No	Muscle Pain		Yes		No
GI Symptoms		Yes		No	GI Symptoms		Yes		No
Body Rash		Yes		No	Body Rash		Yes		No
Travel		Yes		No	Travel		Yes		No
Family member contact COVID-19 symptoms		Yes		No	Family member contact COVID-19 symptoms		Yes		No
Contact with COVID-19		Yes		No	Contact with COVID-19		Yes		No
Latex Allergy		Yes		No	Consent to take dental radiographs if required for clinical diagnosis		Yes		No
					Have you or anyone in your family traveled by air withing Canada in the last 14 days		Yes		No

I understand that carriers of COVID-19 may not exhibit any symptoms and that the virus has an incubation period of up to 14 days or longer before symptoms are apparent. I also understand that it is recommended to maintain social distancing of 2 meters to reduce transmission of COVID-19, and that this is impossible with dental treatment.

I knowingly and willingly consent to having dental treatment completed by doctors and staff at PDG.

Name and Signature of Patient/ Guardian	Date
Name and Signature of Witness	Date