**COVID-19 Emergency Treatment Consent Form**

I **…………………………………………….**, consent to receive emergency treatment from Minty Pearls Dental Clinic during the COVID-19 outbreak. I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that close contact can occur from being within approximately 2 meters of someone with COVID-19 for a prolonged period or by having direct contact with someone with COVID-19. **\_\_\_\_\_\_\_\_**(Initials)

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. **\_\_\_\_\_\_\_\_**(Initials)

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment.   
I understand that the treatment I am receiving is an emergency because of the underlying infection, pain, or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria. **\_\_\_\_\_\_\_\_**(Initials)

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.**\_\_\_\_\_\_\_\_\_\_\_\_\_**(Initials)

*I understand that the symptoms listed below are representative of COVID-19:*

***Fever  
Dry Cough   
Shortness of Breath   
Temperature   
Persistent pain or pressure in the chest   
Loss of Sense of Taste and Smell***

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above. **\_\_\_\_\_\_\_\_\_\_\_**(Initials)

I understand that all travellers arriving from a country or region with widespread ongoing transmission, should stay home for 14 days to practice social distancing and monitor their health after their arrival. I confirm that I have not travelled to any of the countries or regions with widespread ongoing transmission in the past 14 days. \_\_\_\_\_\_(Initials)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

Patient/Guardian Signature: Date: