**KIFER DENTAL SPECIALIST-PEDIATRIC DENTISTRY**

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# COVID-19 Dental Treatment Consent Form

I, _________________________________, knowingly and willingly consent to having emergency dental treatment completed during the COVID-19 pandemic for my child/minor/legal ward (hereafter referred to as "patient").

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. Given the current limits in virus testing,
it is impossible to determine who has it and who does not have COVID-19. Dental procedures create water spray (aerosols), which is one way the disease can be spread. The ultra-fine nature of the spray can linger in the air for several minutes to hours, which can
transmit the COVID-19 virus.

_______ (Initial) I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that the patient and I have an elevated risk of contracting the virus simply by being in a dental office.

_______ (Initial) I have been made aware of the Centers for Disease Control and Prevention (CDC) guidelines that essential preventive care and previously postponed care that may lead to dental emergencies if treatment is not provided in a timely manner may be provided.

_______ (Initial) I confirm I am seeking treatment for the patient for a condition that meets these criteria.

_______ (Initial) I confirm that the patient and I are not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat

_______ (Initial) I understand that air travel significantly increases the risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry.

_______ (Initial) I verify that the patient and I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19.

_______ (Initial) I verify that the patient and I have not traveled within the United States by commercial airline, bus, or train within the past 14 days.

Patient's Name ________________________________

Parent/Guardian's Signature _____________________________________ Date ____________________