

COVID-19 Emergency Treatment Consent Form

I, \_\_\_\_\_ (the parent), consent for \_\_\_\_\_ (the patient) to receive emergency treatment from Santa Barbara Children’s Dental Practice, 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 based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

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 in the practice. (Universal precautions are used at all times with additional disinfection measures throughout the clinic).

I understand that under the CDC and ADA guidelines, do not recommend proceeding with any treatment that is non urgent/emergent at this time.

I understand that the treatment I am receiving is urgent or emergent because of the underlying infection, pain, or conditions that limit my normal day-to-day activities or could potentiate a medical emergency. I confirm I am seeking treatment for a condition that meets these criteria.  
\_\_\_\_\_ (Initial)

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.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Practice Use: Doctor Signature: \_\_\_\_\_