



VANCOUVER ABORIGINAL HEALTH SOCIETY

Annex 4: BCDA Waiver for Patients

COVID 19 PANDEMIC DENTAL TREATMENT CONSENT FORM NEW PATIENT

Patient Name _____ Date: _____

I understand the novel corona virus causes the disease known as COVID-19. I understand the novel corona virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water spray, which is one way the novel corona virus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel corona virus.

Please initial _____

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel corona virus and the characteristics of dental procedures, that I have an elevated risk of contacting the novel corona virus simply by being in a dental office. Please initial _____

I confirm that I am not presenting any of the following symptoms of COVID-19:

- FEVER > 37.5 Initial _____ TEMPERATURE READING: _____
- COUGH Initial _____ (WE WILL TAKE YOUR TEMPERATURE)
- SORE THROAT Initial _____
- SHORTNESS OF BREATH Initial _____
- FLU-LIKE SYMPTOMS Initial _____

I confirm that I am not currently positive for the novel corona virus Initial _____

I confirm that I am not waiting for the results of a laboratory test for the novel corona virus Initial _____

I verify that I have not returned to British Columbia from any country outside of Canada, whether by car, air, bus or train in the past 14 days Initial _____

I understand that any travel from any country outside of Canada, including travel by car, air, bus or train, significantly increases the risk of contracting and transmitting the novel corona virus. B.C.'s Provincial Health Officer requires self-isolation for 14 days from the date a person has returned to Canada Initial _____

I understand the B.C.'s Provincial Health Officer has asked individuals to maintain social distancing of at least 2 meters (6 feet) and it is not possible to maintain and receive dental treatment Initial _____

I verify that I have not been identified as a contact of someone who has tested positive for novel corona virus or been asked to self-isolate by B.C.'s Provincial Health Officer, the Communicable Disease Control or any other governmental health agency Initial _____

Have you had a vaccine? First Vaccine Second Vaccine Booster

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 PANDEMIC.

SIGNATURE OF PATIENT: _____