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Dr. Koterwas Orthodontics
COVID-19 Emergency Treatment Consent Form

I, _____(the patient or parent/guardian if under 18), consent to receive emergency treatment from **Koterwas Orthodontics** 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 aerosol which can be shared through close contact. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 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, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

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.

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

- Fever
- Dry Cough
- Headache
- Severe Fatigue
- Loss of Smell or Taste
- COVID Toes- tingling, pain or abnormal blue/purple spots on one or more toes
- Shortness of Breath or trouble breathing
- Persistent pain or pressure in the chest

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above: _____(Initial)

I confirm that I have not traveled outside of Maryland and if I have I have self-quarantined for 14 days. Per Governor Hogan 3/30/2020: *Out-of-State Travel.* No Marylander should be traveling outside of the state unless such travel is absolutely necessary. Those who have traveled outside of the state should self-quarantine for 14 days. ___ (Initial)

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. _____(Initial)

Patient/Guardian Signature:_____

Date:_____

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OFFICE STAFF USE ONLY:

PATIENT TEMPERATURE:_____

PARENT TEMPERATURE IF THEY ENTERED CLINIC:_____

*Patients with a temperature of 100.2 or higher will not be seen.