Chart Number __________
(for internal use only)

Lindquist Dental Clinic for Children

Parkland * Bremerton

Patient Screening Checklist & COVID-19 Dental Treatment Consent Form

Child's Name:

Last Name ______ First Name ______ Date of Birth ______

Parent's Name:

Last Name ______ First Name ______ Date of Birth ______

Date of Screening: ______________________

	Child	Parent/ Guardian
1. **Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?**	▯ Yes ▯ No	▯ Yes ▯ No
2. **Are you/they in contact with any confirmed COVID-19 positive patients?**	▯ Yes ▯ No	▯ Yes ▯ No
3. Do you/they have a cough?	▯ Yes ▯ No	▯ Yes ▯ No
4. Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	▯ Yes ▯ No	▯ Yes ▯ No
5. Have you/they experienced recent loss of taste or smell?	▯ Yes ▯ No	▯ Yes ▯ No
6. Do you/they have any unexplained rash?	▯ Yes ▯ No	▯ Yes ▯ No
7. Do you/they have shortness of breath?	▯ Yes ▯ No	▯ Yes ▯ No

Screened by: ________________________________

COVID-19 Pandemic Dental Treatment Consent Form

I (the patient or parent/guardian named above) knowingly and willingly consent for (patient's named above) to have dental care during the COVID-19 pandemic.

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. It is impossible to determine who has it and who does not given the current limits in virus testing.

Although LDCC is doing their best to abide by the American Dental Association's and the Center for Disease Control's guidelines for best practice, health and safety during COVID-19:

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 I (or my child) may have an elevated risk of contracting the virus simply by being in a dental office.

Phone number while on site: ____________________________
I will not leave the premises while my child is been seen. I will remain either in the waiting room or in my car.

Signature Parent/Legal Guardian ______________________________ Date ______________

Signature Doctor ______________________________ Date ______________