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COVID-19 PANDEMIC – DISCLOSURE AND CONSENT FORM

I _____, knowingly and willingly consent or for myself or for a minor _____ under my care to have urgent elective or emergency medical treatment during the COVID-19 pandemic.

I understand that:

- People can catch COVID-19 from others who have the virus.
- The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales.
- These droplets land on objects and surfaces around the person.
- Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth.
- People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets.
- This is why it is important to stay more than 1 metre away, especially from a person who is sick.
- The COVID-19 virus has a long incubation period during which carriers of the virus might not show symptoms and still be highly contagious.
- It is impossible to determine per patient/person.

Medical procedures may take place with the patient in close proximity to the medical practitioner. This potentially exposes the patient and the medical practitioner to respiratory droplets which may spread the disease.

- I understand that due to the frequency of visits of other patients, the characteristics of the virus, and the nature of consultations and medical procedures, that I have an elevated risk of obtaining the virus simply by being in a medical practice.

_____ **(Initial)**

- I have been made aware of the National Institute of Communicable Diseases (NICD) guidelines and that under the current pandemic all non-urgent health care is not recommended.

_____ **(Initial)**

- I confirm that I am seeking treatment of an urgent condition.

_____ **(Initial)**

I confirm that I am not presenting with any of the following symptoms of COVID-19 listed below and that I will inform the medical practitioner immediately should I develop these symptoms.

_____ **(Initial)**

- Fever
- Shortness of breath
- Sore throat
- Cough
- Tiredness

Signature:_____ **Date:** _____

Name of Patient / Parent / Guardian _____

I acknowledge that by typing my name in the Signature field above, this declaration is binding