Future Smiles Dental Clinic

COVID-19 Treatment Consent

The Arkansas Department of Health (ADH) has recommended that dental facilities may resume services providing they follow minimal protective equipment guidance. Future Smiles adheres to all ADH guidance and that of the American Dental Association.

I understand that carriers of the virus may not show symptoms, yet, may still be contagious. Since the nature of dentistry does not allow for 6 feet of "social distancing," I understand there may be an increased risk of acquiring or spreading the virus. Dental work often creates aerosols, which carries an added risk of spreading COVID-19.

I confirm that my child has not had any of the following symptoms of COVID-19 for the past 14 days:

- Fever
- Body Aches
- Dry Cough
- Shortness of Breath
- Sore Throat
- Diarrhea or Vomiting

I confirm that I will notify clinic staff if my child or anyone in his/her home develops any of the above symptoms or tests positive for COVID-19.

By signing this form, you acknowledge that in-person treatment for dental conditions presents increased risk of contracting COVID-19. You further acknowledge that for us to perform treatment, we must be closer than the CDC recommended 6 feet.

I consent to allow my child to receive dental treatment at Future Smiles Dental Clinic during the COVID-19 pandemic.

Name of CHILD (Please Print) _____

Parent/Legal Guardian Name (Please Print) _____

_____ _____

Parent/Legal Guardian Signature ***I certify that I have been appointed as the Legal Guardian for the child above.*** **Date**