IDA KSB **Indian Dental Association**
Kerala State Branch
2020-21

COVID 19

INFORMED CONSENT FOR DENTAL TREATMENT

Name : ---------- Age/Sex : ---------- **M/F**

Occupation :---------- Mobile No. : ----------

Address : ---------- Date / Time : ----------

---------- Temperature : ----------

Sl. No.	Particulars	
1.	In the past 45 days, have you been diagnosed with COVID- 19?	Yes ☐ No ☐
	a) If **YES**, have you been hospitalized?	Yes ☐ No ☐
	b) During hospitalization, was oxygen administered?	Yes ☐ No ☐
2.	In the past 10 days, have you or your cohabitants had symptoms like fever, body ache, cough, sneezing, difficulty in breathing, loss of smell/taste, throat pain or conjunctivitis?	Yes ☐ No ☐
3.	Have you or your cohabitants travelled outside the state/ country, in the past 10 days?	Yes ☐ No ☐
4.	Have you been vaccinated against COVID-19?	Yes ☐ No ☐ 1st Dose ☐ 2nd Dose ☐
	a) If **YES**, has 14 days or more elapsed after the administration of the last dose of vaccination?	Yes ☐ No ☐
5.	Are you on medications/treatment for any medical ailments/conditions?	Yes ☐ No ☐
	If **YES**, please elaborate?	

I, ... have come to this Dental Clinic/Hospital for dental treatment. The doctor reserves the right to Treat / Defer/ Refer me accordingly.

If I happen to be an asymptomatic carrier or an undiagnosed patient with Covid-19 disease, I suspect it may danger the doctors and other clinic staff. It is my duty and responsibility to take appropriate precautions and follow the protocols prescribed by them. I also know and understand that I may already be an asymptomatic carrier / undiagnosed COVID-19 positive patient / may get infected due course of time after my visit to the dental clinic and I will not hold the doctors or the staff of the clinic responsible for any future diagnosis of COVID-19 with me or my accompanying person.

The above terms and conditions have been read by me/have been explained to me in my native language to my complete satisfaction. I agree to all terms and conditions mentioned above. I verify, confirm and agree to be held account able, regarding the details given by me which I state are true to the best of my knowledge.

Signature of Patient/Parent Guardian	
Signature of Accompanying Person	

Name of the Dentist & Signature:

KDC Reg. No.

Name of Guardian/Accompanying Person : ..... Mob: No. .....

NB: Not disclosing information or providing false information is a punishable offence under the IPC and Kerala Epidemic Diseases Ordinance 2020