COVID-19 MINOR PATIENT SCREENING AGREEMENT

Student Name ________________________________

Parent/Guardian ________________________________

School/Grade ________________________________

Address ________________________________

City/State/Zip ________________________________

Home Phone ________________ Cell Phone ________________

Email ________________________________

By signing below, I affirm that on the day of dental treatment, my child has **NOT**….

- knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19.
- tested positive for COVID-19 in the past 14 days.
- experienced any of the following symptoms of COVID-19 in the past 14 days:
    - Fever greater than 100 degrees
    - Flu-like symptoms like body aches
    - Abnormal cough
    - Shortness of breath
    - Diarrhea
    - Loss of taste or smell

I understand that if I answer yes to any of the above statements on the day of dental treatment, my child will not be able to participate.

Parent/Guardian: ________________________________

Date: ________________________________

COVENANT
COMMUNITY CARE
"I WAS SICK AND YOU LOOKED AFTER ME"
MATTHEW 25:36