<u>Associate Pediatric Clinic COVID-19 Screening / Consent Form</u>

Patient name(s): ____

We are recommending that all persons visiting the clinic continue to wear a mask while inside the clinic and the waiting room.

If you are unable to wear a mask due to a medical or personal reason, please inform the front staff.

YOU ARE <u>REQUIRED</u> TO INFORM STAFF <u>IMMEDIATELY</u> IF YOU HAVE <u>ANY</u> OF THE FOLLOWING SYMPTOMS:

- Fever > 38°C
- Cough
- Shortness of Breath
- Loss of taste or small
- Runny Nose (if over 18 years old)
- Sore Throat (if over 18 years old)

I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and may be contagious.

______ I verify that **I, nor anyone else in my household including the patient/ dependent** have **not** returned to Alberta from any country outside of Canada whether by car, air, bus or train in the past 14 days. (Initial if you nor anyone in your household have **NOT** travelled)

______ I verify that I am not a confirmed COVID case **or** a close contact to a confirmed COVID case

______ I verify that **I, nor anyone else in my household including the patient/dependent,** do **NOT** have a pending COVID test. (Initial if you **DO NOT** have a pending test)

Parent or Guardian Name (printed) __________________________

Parent or Guardian Signature _______________________________ Date ___________________