RAMAIAH UNIVERSITY OF APPLIED SCIENCES

Faculty of Dental Sciences

Reference no: HICC/FDS/003 15th May, 2020

Notification

Informed Consent

I, _____, knowingly and willingly consent to undergo dental treatment during COVID-19 pandemic.

1. I understand COVID-19 has a long incubation period during which carriers of the virus may not may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.
2. If I am an asymptomatic carrier or an undiagnosed patient with COVID-19, I suspect it may endanger Dental Health Care Personnel (DHCP). It is my responsibility to take appropriate precautions and to follow the protocols prescribed by them.
3. I am aware that the DHCP will adopt appropriate infection control and prevention practices to avert any COVID-19 cross-infection from happening. However, I will not hold any DHCP accountable if such infection occurs to me or my attendants.
4. In case I or my attendants get COVID-19 infection after the visit to the clinic, I will inform the clinic authorities at the earliest. So, the appropriate tracking of patients/attendants and DHCP on the day of my visit can be done.
5. I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:
    A. Fever
    B. Shortness of breath
    C. Loss of sense of taste or smell
    D. Dry cough
    E. Runny nose
    F. Sore throat

    Initials: _____
6. I understand the government recommends physical distancing of at least two meters or one meter as a norm to be followed at all places.
7. I understand that one has to go for quarantine/self- isolation for a period of fourteen days if the person has arrived from risky areas/come in contact with COVID-19 positive case/come in contact with anyone who has shown symptoms.
8. I confirm that I have not travelled outside of India in past fourteen days to countries that have been affected.
9. I confirm that I have not travelled domestic within India by commercial airlines, bus or train or any other means of transport within the past fourteen days.
10. I consent to undergo RT-PCR test if suggested by the clinician at my own cost and found positive, treatment can be deferred.
11. I confirm the information I have provided on this form is truthful and accurate. I, knowingly and willingly, consent for treatment during COVID-19 pandemic. If I hide my facts and relevant details, and because of

knowing or unknowing actions or behaviors, the DHCP gets infected, I may be held responsible for appropriate compensation in the court of law if I am found guilty.

Name _____ Sign/thumb impression _____

Date _____