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COVID – 19 PANDEMIC – DISCLOSURE AND CONSENT FORM

I _____, Knowingly and willingly give consent or for myself or for a minor _____ under my care for urgent elective or emergency medical treatment during the COVID – 19 pandemic.

I understand that:

- People can catch COVID – 19 from others who have the virus
- The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID – 19 coughs or exhales.
- Other people can then catch COVID – 19 by touching these objects or surfaces, then touching their eyes, nose, or mouth
- People can also catch COVID – 19 if they breathe in droplets from a person with COVID – 19 who coughs out or exhales droplets
- Therefore, it is important to keep your distance for more than 1 meter away, especially from a person who is sick
- The COVID – 19 virus has a long incubation period during which carriers of the virus might not show symptoms and still be highly contagious.
- It is impossible to determine per patient / person.

Medical procedures may take place with the patient in close proximity to the medical practitioner. This potentially exposes to patients and the medical practitioner to respiratory droplets which may spread the disease

- I understand that all doctors and patients undergo screening at hospital and practise and that all necessary measures are taken to prevent the spread of the virus but cannot be 100% full proof due to incubation period. (initial) _____
- I confirm that I am seeking treatment to prevent the further deterioration of my quality of life. (initial) _____

I confirm that I am not presenting with any of the following symptoms of COVID – 19 listed below (and that I will inform the medical practitioner immediately should I develop these symptoms) (Initial) _____

*Fever	*Shortness of breath
*Sore throat	*Cough
*Tiredness	

Signature _____ Date _____

Name of Patient / Parent / Guardian _____