LONG BEACH SPEECH PATHOLOGY
COVID-19 PANDEMIC - SPEECH/MYOFUNCTIONAL TREATMENT
ACKNOWLEDGEMENT AND CONSENT FORM

The goal of Long Beach Speech Pathology Services is to provide a safe environment for its patients. This document provides information that you need to understand and acknowledge regarding the COVID-19 virus.

According to the CDC the COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a **pandemic**. You could contract COVID-19 from a variety of sources. This practice wants to ensure you are aware of the additional risks of contracting COVID-19 while receiving treatment from Long Beach Speech Pathology Services.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated.

I understand that due to the frequency and timing of visits by other speech therapy patients, and the characteristics of the virus, there is an elevated risk to me, my child, and my family, of contracting the virus simply by being in this clinic which is housed in a medical building. _____ (Initial)

I understand that while my child is receiving speech and myofunctional treatment, they cannot wear a protective mask over their mouth to prevent infection during treatment, as the therapist will need access to my child's mouth to render care. This leaves my child vulnerable to COVID-19 transmission while receiving therapy. _____ (Initial)

I confirm that I (the parent) am not presenting any of these COVID-19 symptoms: Fever, Shortness of Breath, Dry Cough, Runny Nose, Sore Throat. I also affirm that my child does not present with any of these symptoms either. _____ (Initial)

I confirm that we (those in my household) have not been in contact with a person who has been diagnosed with COVID-19 within the past 14 days. _____ (Initial)

I confirm that I have read the above and understand and accept the increased risk of contracting the COVID-19 virus (for me and my child) in this speech clinic or with treatment provided by Long Beach Speech Pathology Services.

I have read and understand the information stated above:

Printed Name: _____
(Parent)

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____
(Parent)