INFORMED CONSENT FOR PEDIATRIC SEDATION IN DENTAL PRACTICE

State law requires that health professionals provide the parents/legal guardian with information regarding the treatment and procedures that are being recommended for their child. State law further requires that the health professional providing the treatment obtain the parents/legal guardian's signed consent for specific dental treatment, procedures, and techniques which are being recommended for their child.

Signed informed consent indicates you are awareness of sufficient information to allow you to make an informed and voluntary personal choice concerning you child's dental care after considering the risks, benefits, and alternatives.

Please read this form carefully and ask any questions that will assist you in making an informed consent. We will be pleased to explain all information and answer any questions to the best of our ability, as a qualified dental health professionals, to your satisfaction.

1. **Purpose of Pediatric Sedation**

For those children who are anxious, fearful and unable to cooperate and/or for those children whose treatment may require multiple visits that could cause undue stress and discomfort, the doctor may recommend that necessary dental treatment be performed utilizing pediatric conscious sedation. Conscious sedation is achieved by having the child swallow a liquid medication/s that, after a short period of time, will minimally depress the child's level of consciousness. The child will independently maintain their ability to respond to verbal commands and physical stimulation. The child will independently and continuously maintain all reflexes, airway, breathing, and cardiovascular functions spontaneously and is continually monitored for compliance.
It has been discussed and described to me and I fully understand the following:

A) That a sedative medication/s will be prescribed for my child by the doctor as deemed appropriate to enable the doctor and staff to perform necessary dental treatment.
B) That the level of sedation using oral medication/s prescribed may vary considerably from child to child. Some children may be calm and quiet throughout procedure. Sedative medications often produce amnesic effects where the child may have trouble recalling what happened while sedated or simply not remember anything.
C) That the possible medical risks orally administrated sedative drug/s have been discussed and that I fully understand these medical risks. These medical risks include: drug allergy, airway and breathing difficulties, and cardiovascular problems that can result in hospitalization, disabilities, and death. The safety of pediatrics oral conscious sedation has been well documented and is of utmost concern for the doctor and staff. (Risks discussion)
D) That is imperative that my child not have anything to eat for 8 hours or drink for 8 hours prior to the sedation procedure.
E) That the benefits for using orally administered sedative drug/s for sedation to allow my child to obtain needed dental care have been explained. (Benefits discussion)
F) That the alternative to the use of oral sedative medication/s may include but are not limited: to 1) neglect of dental care with the possible pain and suffering 2) use of deeper sedation methods such as intravenous sedation or general anesthesia.(Alternative discussion)

G) That I will not be allowed to be with my child in the sedation room and that I will not leave the office during the time that my child is in the sedation room.

H) That my child may be irritable and agitated while wearing the onset of the sedative effects. Drowsiness, lack of coordination, inability to remain upright, etc., may occur in the reception room prior to treatment and that I will supervise all activities during this period to prevent any injuries to my child.

I) That certain protective and physical positioning equipment and devices will be used during my child's sedation and dental procedure that minimize the movement of m child that could cause harm. These protective and positioning devises include but not limited to:
   i. Body Wrap(papoose board) and head immobilizer
   ii. Neck, elbow and knee positioners
   iii. Mouth opening devises(mouth prop)
   iv. Nitrous oxide mask and tubes
   v. Tooth isolation devises(tooth clamp and rubber dam)
   vi. Monitoring probes and instruments

J) That a certain behavior management and pain control methods may be employed such as voice control, non-verbal communications, nitrous oxide analgesia, and local anesthesia.

K) That certain complication may result from either the sedation procedure, the dental procedure, or both, and may include but are not limited to; sweating, swallowing of a foreign object, lacerations of oral structures, mouth numbness, post-treatment lip, tongue, or cheek biting, post-treatment swelling from local anesthesia, mouth bleeding, nose bleeding, skin irritation, discoloration or bruising, nausea, vomiting, allergic reaction, loss of bladder or bowl control, temporary elevated body temperature, and other conditions that may not require hospitalization.

L) That I must supervise my child and all activities after the sedation appointment for at least 24 hours from discharge. That an age appropriate car seat and seat belt will be used in compliance with state law when transporting my child home from treatment. A responsible adult will be seated next to my child while my child is being transported home to assure my child's neck and head remain upright so that the airway and breathing are not impaired.

M) That I will comply with all preoperative instructions given to me by the doctor and staff.

2. **Acknowledgement of informed consent.**

I acknowledge that the above information has been described and discussed with me and that I have read(or it has been read to me) and that I acknowledge and understand fully this informed consent for the use of pediatric oral conscious sedation in the dental treatment of my child as discussed and described.

I acknowledge that I have been made aware of the risks, benefits, and alternatives to pediatric oral conscious sedation, that a potential hazard and problems were discussed in details, and that I had the opportunity to ask questions to the best of my ability and received answers to those questions to the best ability of the doctor and staff.

I acknowledge and fully understand that the intention of pediatric sedation is to render my child minimally or moderately sedated and not to render my child unconscious during dental treatment.
I acknowledge and fully understand I have been given and maintain the option to have certain procedures performed under general anesthesia in hospital setting. After being fully informed of this option, I elect to perform treatment under oral sedation in this office.
I acknowledge and fully understand that I will not be allowed to be with my child in the sedation room and that I will not leave the office premises while my child is in the sedation room.

I understand that no guarantees or assurance have been made to me about the ultimate results of the above mentioned procedures. I understand that this consent will remain in effect until terminated by me.

Parent or Guardian Signature:_____ **Date:**_____