ORAL CONSCIOUS SEDATION CONSENT

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:

1. 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.

2. 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 the procedure while others may be fussy and cry. Although their level of consciousness is depressed, the child will react to verbal commands and physical stimulation. Every effort will be made to minimize any stress and discomfort from the procedure. Sedative medications often produce amnesic effects where the child may have trouble recalling what happened while sedated or simply not remember.

3. That the possible medical risks of orally administered sedative drug(s) have been discussed and that I understand these medical risks. These medical risks may include: drug allergy, airway and breathing difficulties, and cardiovascular problems that can result in hospitalization, disabilities, and death. The safety of pediatric oral conscious sedation has been well documented and is of utmost concern for the doctor and staff.

4. That it is imperative that my child did not have anything to eat or drink after midnight prior to the sedation procedure.

5. That the benefits for using orally administered sedative drug(s) for sedation to allow my child to obtain needed dental care have been explained.

6. That the alternatives to the use of oral sedative medication(s) may include but are not limited to: a) neglect of dental care with possible pain and suffering; and b) use of deeper sedation methods such as intravenous sedation or general anesthesia.

7. I will not leave the office during the time that my child is in the sedation room.

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

9. That certain protective and physical positioning equipment and devices will be used during my child's sedation and dental procedures that minimize the movement of my child that could cause harm. These protective and positioning devices include but are not limited to:

   A) Body wrap (papoose board) and head immobilizer
   B) Neck, elbow and knee positioners
   C) Mouth opening devises (mouth prop)
   D) Nitrous oxide mask and tubes
   E) Tooth isolation devises (tooth clamp and rubber dam)
   F) Monitoring probes and instruments

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

11. That certain complications may result from either the sedation procedure, the dental procedures, 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 reactions, loss of bladder or bowel control, temporary elevated body temperature, and other conditions that may or may not require hospitalization.

12. 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 airway and breathing are not impaired.

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

14. I have reviewed the Sedation Instructions Form and all of my questions regarding the procedure have been answered.

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 it has been discussed and described to me and that I fully understand the need and use for protective, physical restraint, and positioning devises, and other behavior management methods that are intended to minimize any untoward movements during my child's sedation appointment.

I acknowledge that I have been made aware of the risks, benefits, and alternatives to pediatric oral conscious sedation, that potential hazards and problems were discussed in detail, and that I had the opportunity to ask questions to the best of my ability and receive 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 understand that no guarantees or assurances 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's Name: Relationship to child

Child's Name: Date:

Signature: