CONSENT FOR USE OF SEDATION

I, _____, as the legally responsible parent/guardian of _____, give my consent to the use of local anesthesia and sedative drugs as deemed appropriate by the judgment of Dr. Davis and Dr. Shingler so as to enable to render necessary dental treatment as indicated on the child's examination chart, as previously explained to me or as noted from today's examination and x-rays. I understand the dental procedures planned to treat the child's dental decay will include:

_____
_____.

I certify that _____has had nothing to eat or drink since_____.

I have been informed and understand that occasionally, there are complications of the treatment drugs, or anesthetic agents; including but not limited to numbness, infection, discoloration, nausea, vomiting, aspiration, allergic reactions, breathing difficulties or brain damage. I further understand and except the complications may require medical assistance or hospitalization and may even result in death.

I acknowledge the receipt of and understand the sedation instructions. The treatment and sedation procedure have been explained to me, to my satisfaction, along with possible alternative methods, their advantages and disadvantages. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied whether as to the result of the treatment or as to the cure.

In order to protect my child from harm during treatment, I understand it is necessary to give my permission for Dr. Davis, Dr. Shingler, and/or the staff to physically restrain my child during the course of treatment to assure his/her safe treatment and care. I understand other techniques will include:

A Papoose: "sleeping bag" used to restrain arms and legs.
Mouth Props: A "tooth pillow" that helps patients open their mouth.
Knee or Elbow Guards: "robot legs/arms" used to restrain arms and legs

I have read and understand the above, including the risk of treatment and treatment refusal and have no further questions.

Legally responsible
parent/guardian:_____Date:_____

Witness: _____Date:_____

I certify that I explained the above procedures to the parent/guardian and answered all questions before requesting the signature.

Doctor:_____Date:_____