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CONSENT FOR THE USE OF SEDATION OR GENERAL ANESTHESIA FOR PEDIATRIC DENTAL TREATMENT

I _____,as the legally responsible parent or guardian of _____give my consent to the use of local anesthetics, sedation drugs or general anesthetic agents that Dr(s)._____ may deem necessary on the child's examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned treatment for _____, except for: (if none, so state) _____.

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, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, stroke, or heart attack. I further understand and accept that complications may require hospitalization and may even result in death.

Dr(s). _____ discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the preoperative and postoperative instructions. The treatment and sedation or anesthesia procedures have been explained to me, to my satisfaction, along with possible alternative methods and their advantages and disadvantages; risks, consequences, and probable effectiveness, as well as the prognosis if no treatment is provided.

I have read this consent and understand, to my satisfaction, the procedures to be performed and accept the possible risks.

Legally responsible parent or guardian: _____ Date: _____

Address: _____

Witness: _____

I certify that I explained the above procedures to the parent before requesting his or her signature.

_____ Date: _____
Signature of dentist

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HEALTH AND PHYSICAL EXAMINATION FOR DENTAL TREATMENT UNDER GA SEDATION

Pediatrician: _____
Address: _____
_____
Phone: _____

Patient Name: _____ D. O. B.:_____

CHIEF COMPLAINTS/HPI:

PMH
Disease of childhood:

Hospitalizations:

Medications:

Allergies:

Immunizations:

Others:

FAMILY HISTORY:

REVIEW OF SYSTEMS:

PHYSYCAL EXAMINATION:
Vital signs:
BP_____/_____ P_____ R_____
T_____ WT._____

Airway assessment: _____
IMPRESSION AND RECOMMENDATION:

Signature: _____ Date_____