Consent for Sedation

Patient Name _____ Date of Birth _____

I hereby authorize Dr. Will MacDonald/or Dr. R. Michael Myers to perform necessary dental treatment on my child utilizing conscious sedation techniques. I also authorize, if it is deemed necessary by my child's dentist, the use of intravenous sedation administered by a certified anesthesiologist, Dr. Jimmy Rawls. I understand that my child is either unable to be treated in a cooperative patient /doctor setting using usual and customary dental techniques or the procedures require the need for conscious sedation or intravenous sedation. The purpose and nature of the need for conscious sedation has been fully explained to me. I understand the consequences if my child has any food or liquids within six hours prior to sedation.

I fully understand there is possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability, and system impairment, permanent or temporary nerve damage, brain damage or death. It is important to understand that in the doctors' combined experience of over 40 years of sedations, no serious situations have arisen. However, our office takes each sedation seriously and uses medications and dosages that are recommended by the American Academy of Pediatric Dentistry. I further authorize or Dr. Will MacDonald/ or Dr. R. Michael Myers to perform treatment as may be advisable to preserve the health and life of my child.

I understand that it is my obligation to monitor my child following discharge from this office. They should not stand, walk, or ride bikes, on their own for a few hours to avoid any head injuries that may arise due to temporarily impaired balance.

I understand that sedation may prove partially or completely ineffective in managing my child. In such an instance the planned treatment may not be possible or may require several appointments using these conscious sedation techniques to complete the necessary dental work and/or an alternative treatment may be instituted.

I have been provided with an explanation of alternatives to treatment and understand the risks of not being treated for the dental condition.

I have carefully read the above and in addition have had all of my questions in regard to sedation to be administered, the outlined risks, and side effects answered.

I do give my free and voluntary informed consent to the same.

Date _____ Time _____

Signature _____ Relationship _____

Witness _____

DR. MIKE | DR. WILL

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