

## CONSENT FOR CONSCIOUS (ORAL) SEDATION

### Demerol/Vistaril

I request and authorize the use of conscious sedation and dental treatment for:

**Patient's name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I, \_\_\_\_\_ as the legally responsible parent/guardian of this child, do authorize the use of sedative drugs **Demerol/Vistaril** and/or nitrous oxide that Dr. Brink or Dr. Sheppard may need to use in order to perform necessary dental treatment. I understand that my child is unable to be treated using non-pharmacological dental behavior techniques and thus the need for conscious sedation.

- ❖ Factors considered when administering a sedative drug include medical history, previous reactions to drugs, age, weight, behavior of the child, and the treatment to be accomplished. Despite such considerations, the child's reaction may vary from little effect to profound sedation.
- ❖ Although the occurrence is extremely remote, some risks are known to be associated with sedations. These risks may include--but are not limited to--nausea, vomiting, breathing problems and allergic reactions. I further understand that some of these complications may require hospitalization or may even result in death.
- ❖ In addition to the sedative medication, nitrous oxide and oxygen may be used to supplement the sedation. Risks and complications with nitrous oxide are rare, and its effects are completely gone five minutes after it is stopped. The most common complications are nausea and vomiting.
- ❖ Proper and acceptable measures will be taken to optimize your child's safety and to achieve quality pediatric dentistry. However, the possibility and nature of complications cannot be accurately anticipated; therefore there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure. Treatment may be discontinued if the sedation proves completely or partially ineffective.
- ❖ Dr. Brink, Dr. Sheppard and their staff have discussed with me, to my satisfaction, the purpose and complications of sedation, the pre-operative and post-operative instructions, the alternatives available to treatment and their advantages and disadvantages.
- ❖ I hereby state that I have read and understand the consent form and that all of my questions have been answered satisfactorily. With the signing of this statement, I give a knowing and voluntary informed consent to administer conscious sedation to my child.

**NOTE:** Sedation medications will cause dizziness and drowsiness. Therefore, I acknowledge being informed of this and will monitor and care for my child during the pre & post-treatment time periods to prevent injury or harm. \_\_\_\_\_ (INITIALS)

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**I certify that the above procedures were explained to the parent/guardian before requesting his/her signature.**

\_\_\_\_\_  
Joshua A. Brink, D.D.S.

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Emily M. Sheppard, D.D.S.