Patient Name: **Date of Birth:**

Informed Consent Form: Oral Conscious Sedation

The purpose of this document is to provide an opportunity for the child's **legally responsible parent/guardian** to understand and give permission for oral conscious sedation of the child in conjunction with his/her dental treatment.

The parent/guardian should initial each item after an opportunity for discussion and ask questions.

_____**1.** I understand that the **purpose** of oral conscious sedation is to achieve minimal/moderate sedation facilitating my child to receive necessary care more comfortably. Minimal/moderate sedation is not required to provide the necessary dental care. I understand that minimal/moderate sedation has limitations and risks and absolute success cannot be guaranteed. (See #4 for alternative options.)

_____ **2**. I understand that minimal/moderate sedation is a drug-induced state of reduced awareness and decreased ability to respond. The **goal** of minimal/moderate sedation is not sleep, however my child may be relaxed enough to fall asleep. His/her ability to respond normally will return when the effects of the sedative(s) wear off.

_____ **3**. I understand that the medication for my child's sedation will be administered via the following route: Oral Administration. My child will take the medication at the beginning of the appointment. The effect of sedation may last from 3 up to 12 hours.

_____ **4.** I understand that the **alternatives** to minimal/moderate sedation are:
A. No treatment: Existing condition(s) can worsen. Adverse consequences of no treatment may include but not limited to pain, infection, swelling, deterioration of the bone around the teeth, changes in bite, jaw discomfort, premature loss of teeth and space, emergency medical attention and/or hospitalization.

B. Deep sedation/general anesthesia: A controlled state of unconsciousness that requires the services of an anesthesia professional. In this case, the patient would need to seek treatment elsewhere.

_____ **5.** I understand that there are **risks** or **limitations** to all procedures. For minimal/moderate sedation the possible risks or limitations include:
A. Inadequate sedation and/or paroxysmal reaction (sudden outburst of emotion) may necessitate the patient to complete the procedure without effective sedation, re-schedule the procedure for another time, and/or choose an alternative form of sedation.

B. Deeper-than-anticipated sedation may require premature termination of treatment, administering reversal agent to reduce sedation, prolonging appointment time for observation, and other measures necessary to ensure my child's wellbeing.

C. Possible **complications** of sedative drugs include but not limited to dizziness, sweating, dry mouth, nausea/vomiting, GI discomfort, allergic reaction, seizures, and respiratory depression.

D. Atypical reactions to sedative drugs, which may require emergency medical attention, result in hospitalization, and may even result in death.

_____ **6.** I understand that I **must notify** the doctor about all of my child's mental and physical condition, including any allergy or sensitivity to any medications, and if he/she is presently on any medications.

_____ **7**. I understand that, to ensure a safe sedation procedure, I must be **present** in the office during the entire sedation procedure. If, during the procedure, a change in treatment is required, I will be asked to make a treatment decision for my child in a timely manner.

_____ **8.** I confirm the receipt of and understand the before, during, and after sedation **instructions**.

_____ **9.** I understand that it is extremely important that my child has **no food or medications 6 hours before sedation**.

Patient Name: **Date of Birth:**

_____ **10.** I have had the opportunity to discuss minimal/moderate sedation of my child, and have my **questions answered** by qualified personnel. I also understand that I must follow all the recommended treatments and instructions of my doctor for the best care of my child.

_____ **11**. I am aware that only sedation personnel are allowed in the operatory, and I will be asked to remain in the waiting area during my child's sedation appointment. I understand that this is for the safety and wellbeing of my child, allowing the doctor to focus solely on my child.

_____ **12**. I understand that protective stabilization equipment will be used such as a papoose or "sleeping bag" and bite block to ensure the utmost safety of my child. This allows the doctor to work quickly and efficiently and is only used once the child is under the effects of the sedative.

_____**13**. I understand that every reasonable effort will be made to ensure that the oral conscious sedation procedure is completed safely and efficiently, although it is **not possible to guarantee results.**

_____**14**. I understand that someone will contact me 24-48 hours before my appointment to reserve my time. I understand that there are other children in need of treatment that could be seen at this time and it is very important that I give 24 hours' notice if I need to reschedule. If Smile Stars does not hear from me within 24 hours, my appointment will be cancelled and may not be rescheduled.

I can be reached at the following **two phone numbers** (_____) _____-_____ **or** (____) _____-_____.

With regard to my child, I voluntarily request Dr. Steve Ripple and/or such associates and/or assistants as he may designate to utilize the following sedative agents, which are deemed necessary or advised to facilitate the rendering of necessary dental treatment.

Midazolam (Versed) oral
Hydroxyzine (Vistaril)

I am the legally responsible parent/guardian, and I hereby consent to oral conscious sedation of my child in conjunction with his/her dental care.

_____
Signature

_____
Parent/Legal Guardian (**print**)

___/___/_____
Date

_____
Witness

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