Consent to Administer
Light Sedation and/or Nitrous Oxide for Dental Treatment

Some children cannot receive dental treatment in the usual manner due to their young age, anxiety, fear, previous dental experience, or nervousness. Options for these children include the following: 1) delaying treatment, 2) restraining the child to accomplish whatever urgent care is required, 3) sedating the child to a level at which dental care can be provided comfortably, 4) giving the child a general anesthetic in the hospital, or 5) proceeding with the treatment under less than optimal conditions. These possibilities all include various advantages, disadvantages, and risks. Delaying treatment may allow dental disease to progress to an emergency situation, including abscess formation, infection, pain, fever, and risk to the developing permanent teeth, or contribute to a long term dental problem. Upsetting or restraining a child may increase fear of dental treatment, and general anesthesia may adversely affect some children, not to mention the risk.

Factors considered when administering sedative drugs 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 to sedative drugs varies from little effect to profound sedation. Unfavorable reactions to sedative drugs include, but are not limited to nausea, vomiting, dizziness, breathing problems, allergic reactions, coma, and death. In addition to the sedative medication, nitrous oxide and oxygen may be used to supplement the sedation and deliver oxygen. Risks and complications with nitrous oxide are rare, and its effects are usually gone five (5) 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, you are given no guarantees or assurances of any sort as to the results that may be obtained. These measures may include a papoose board to prevent sudden movements or other measures which will provide your child a secure environment. Additionally, local anesthesia for pain control will be used. The risks involved for local anesthesia are as stated for sedative medications.

I certify that I have read and understand the above information and have had any and all questions concerning the procedures, dental materials being used, risks, and complications answered to my satisfaction. With the signing of this statement, I give Dr. Tarver, Dr. Scheps, Dr. Depew and/or Dr. Luce a knowing and voluntary informed consent to administer light sedation and/or nitrous oxide to my child.

______________________	______________________	______________________
Child's Name	Date of Birth	Date

______________________	______________________	______________________
Legal Guardian's Signature	Please Print Name	Relationship to Child

I AGREE TO NOT LEAVE THE OFFICE DURING MY CHILD'S TREATMENT.

(____)
INITIAL

If needed, I give permission for my child to be secured with a papoose board for their safety.

______________________	______________________
LEGAL GUARDIAN'S SIGNATURE	PLEASE PRINT NAME

DENTISTRY FOR CHILDREN

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I as parent of (________________________________) (________________) give
First and last name of patient — Patient's date of birth

permission for, (________________________________) to accompany and give full consent to
First and last name of person bringing child to appointment

Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their office staff for the following dental procedures: examination, cleaning, fluoride application, required x-rays for proper diagnosis, necessary for treatment, conscious sedation, and nitrous oxide.

I consent and authorize Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their staff to discuss personal medical/dental history about my child with the above authorized adult.

I request and authorize Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their office staff to examine, clean, apply fluoride and provide my child with comprehensive dental treatment include but not limited to: silver/white fillings, crowns, extractions, impressions, space maintainers, pediatric bridge, sealants, conscious sedation, and nitrous oxide. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Tarver, Dr. Scheps, Dr. Depew, and Dr. Luce to diagnose and/or treat my child's dental condition.

I understand that dental treatment may change. I authorize the above adult to consent to any treatment changes considered necessary by the dentists.

All of my questions have been answered to my complete satisfaction and I give full permission to Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their office staff to treat my child. I understand that I will be responsible for any charges incurred on my child for dental treatment.

______________________________	______________________
Print name of Parent or Legal Guardian	Relationship to Child
______________________________	______________________
Signature	Today's Date

Please provide our office with a phone number in case we need to contact you on the day of your child's dental appointment.*

______________________________	______________________
Phone number you can be reached on day of appointment	Date of Appointment