DRS. KEARNS, ASHBY, RAJCHEL & ASSOCIATES

DENTISTRY FOR INFANTS, CHILDREN & TEENS

DWIGHT J. ASHBY D.D.S. **NANCY L. RAJCHEL, D.D.S.** **JEFFREY D. KEARNS, D.D.S.**

4836 EAST TRINDLE ROAD
MECHANICSBURG, PA 17055
(717) 737-5834

4509 UNION DEPOSIT ROAD
HARRISBURG, PA 17111
(717) 558-9830

CONSENT FOR SEDATION

I, _____, as a legally responsible
Parent/Legal Guardian/Authorized Individual

person (as the legally responsible parent/guardian) of:

_____
Patient's Name

Give my consent to the use of local anesthetics, nitrous oxide and sedative medications as deemed appropriate by Drs. Kearns, Ashby or Rajchel to perform dental treatment as indicated on my child's examination chart and as previously explained to me. I understand that treatment needs can change once the treatment has begun.

I have been informed and understand that rarely complications result from the sedative drugs, including but not limited to nausea, vomiting, allergic reaction and respiratory and/or cardiovascular problems that could lead to death. Some children will experience a paradoxical reaction which makes them combative, non-consolable and "wild" for several hours. This is called "emergence delirium" and is a rare occurrence.

Dr. Kearns, Ashby, Rajchel or Reid or a member of their staff has discussed with me, to my satisfaction, these complications and the related risks. The treatment and sedation procedures have been explained to me, to my satisfaction, along with possible alternative methods and their advantages and disadvantages.

I understand that my child is not to have had any food or liquids after midnight prior to sedation procedures and that he/she is not permitted to leave the building after the sedative has been taken. I also understand that I, or an authorized individual, must remain in the office during my child's entire procedure.

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

Legally responsible person (parent/guardian) _____
Signature

_____ _____
Print Name Date

Witness: _____

Initials: _____ Date: _____

Initials: _____ Date: _____