

KEARNS & ASHBY, D.D.S., P.C.

CHILDREN'S AND ADOLESCENT'S DENTISTRY

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

4836 EAST TRINDLE ROAD
MECHANICSBURG, PA 17055
(717) 737-5834
FAX: (717) 737-2158

4509 UNION DEPOSIT ROAD
HARRISBURG, PA 17111
(717) 558-9830
FAX: (717) 558-9844

CONSENT FOR NITROUS OXIDE

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

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

Patient's Name

give my consent for the use of Nitrous Oxide/Oxygen (laughing gas, happy air) as deemed appropriate by Drs. Kearns, Ashby, Rajchel or Kearns to help control anxiety for the child named above during today's dental treatment.

I have been informed that the Nitrous Oxide may make my child feel "tingly" or "floaty" and that the Nitrous Oxide will be completely dissipated from the patient's system after 2 to 3 minutes of breathing room air. I also understand that, while it rarely occurs, nausea is a possible adverse affect of the Nitrous Oxide.

I 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

_____ Date
Print Name

Witness: _____

Initials: _____ Date: _____ Witness: _____

Initials: _____ Date: _____ Witness: _____

Initials: _____ Date: _____ Witness: _____