Consent for Sedation/Anesthesia

**** I hereby authorize Dr. Rana L. Mathias to perform necessary dental treatment on my child/legal ward utilizing conscious sedation techniques. I understand that my child is either unable to be treated in a cooperative patient-doctor setting using usual and customary dental techniques or the procedure requires the need for conscious sedation. The purpose and nature of the need for conscious sedation has been fully explained to me.

** I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability, and system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Rana L. Mathias to perform treatment as may be advisable to preserve the health and life of my child or legal ward.

** I understand that sedation may prove partially or completely ineffective in managing my child or legal ward. In such an instance the planned treatment may not be possible or may require several appointments using these conscious sedation techniques to complete the necessary dental work and/or alternative treatment may be instituted.

** I have been provided with an explanation of alternatives to treatment and understand the risks of not being treatment for the dental condition.

** I have carefully read the above and in addition have had all of my questions answered in regard to sedation to be administered, the outlined risks, and side effects.

** I do give my free and voluntary informed consent to the same.

Signature _____ Date_____

Relationship to child _____

Witness _____