Kids Dental Center, LLC
SPECIALISTS IN PEDIATRIC AND ADOLESCENT DENTISTRY
DANIEL E. BIEDERMAN, D.D.S., F.A.A.P.
Diplomate, American Board Pediatric Dentistry
5060 DORSEY HALL DRIVE, SUITE 104
ELLICOTT CITY, MD 21042
410-465-6000/410-740-0606

CONSENT FOR USE OF SEDATIVE MEDICATIONS

I, _____ as the Parent/Legal guardian of _____,
Hereby authorize Daniel E. Biederman, D.D.S., & Kids Dental Center, LLC to administer sedative medications for the purpose of performing the following dental procedures:

_____

_____

_____

The purpose of the sedative medications is to make dental treatment easier and more accessible for your child without having to resort to general anesthesia (which may be an alternative method of treatment). The intention of administering this medication is to:

1. Help allay some of your child's anxieties;
2. Make your child more calm and relaxed; and,
3. Decrease non-cooperative &/or inappropriate behavior that prevent safe and successful dental treatment.

It is also important to understand what the Sedative medication does not do.
The sedative medication will NOT:

1. Make your child happy to be at the dentist office, or happy to have dental treatment performed.
2. Feel no pain.
3. Act more mature, more grown-up, or increase their cognitive reasoning/ rationale.
4. Sleep (while some children may fall asleep due to a greater than anticipated response to the medication, this is not the intent, nor the desire. If your child does fall asleep, dental treatment will stop, and your child will be monitored until they awaken.

All medications have side effects and risks. The medication which I have selected for your child is Versed (similar to Valium, but is faster to take effect, faster to wear off, and has "Forward" amnesia). I chose this medication because of its high therapeutic efficacy, minimal side effects, and availability of a reversal agent. The medication will be administered orally (by mouth). Common side effects include slower, deeper respirations (breaths), and increased mucous secretions in the lungs and throat, decreased balance and reflexes, depressed cognitive function, as well as visual and auditory hallucinations. The child may appear to act "drunk". These side effects may be undesirable in a person who has sleep apnea, snore, or have large tonsils or adenoids or other respiratory concerns. Please alert Dr. Biederman prior to your child taking any medication if these conditions exist, and of any medical problems or diagnoses.

Additionally, I may be administrating nitrous-oxide/oxygen ("laughing gas") via nasal mask, and utilizing a local anesthetic ('Articaine') to numb the teeth. Some children are resistant to any therapeutic measures and need physical restraint and stabilization. If such restraint is needed I will ask you at the time to aid, if possible. Your presence during the procedure is advised but under some circumstances I may ask that you leave (go beyond your child's line of sight). **I also request no verbal communication between parent and child during the procedure**. Unfortunately, there are a few children who are resistant to behavior modification techniques, verbal explanations, medications, and physical restraint. Under such circumstances a general anesthetic in an outpatient hospital facility may be the only reasonable and most appropriate alternative.

In order to minimize the inherent risks of medications and provide a safer and more enjoyable dental visit I would ask you comply with the following guidelines.

I. Dietary guidelines. **DO NOT EAT food, milk, or liquids after midnight prior to the dental treatment**. If your child if required to take a daily prescribed medication in the morning, please specifically address Dr. Biederman.

II. General health. **If your child develops a cold, flu, fever, or is taking medication for a recent illness (other than those already discussed with Dr. Biederman) within 2 weeks of the scheduled procedure, the procedure will probably need to be rescheduled**. Please contact our office at once so we can make different arrangements.

III. Following the procedure.

1. Your child will need direct parental supervision for a minimum of six hours. Sleep or seated, calm indoor play under direct parental supervision is advised. Do not allow your child to stand or walk without direct physical support during this time.
2. Your child **will NOT** return to school, or day care until the following day.
3. Your child **will NOT** participate in any sports or physical activities which require judgment, reflexes, balance or cognitive thought, i.e. bicycling, skating, catch, etc. for the remainder of the day.
4. Your child **will NOT** take a bath or shower, or go to the bathroom unattended or physically unsupported for the remainder of the day.
5. Eating solid foods should be curtailed for a minimum of two hours or until any local anesthetics (Articaine) has worn off.
6. Going up and down stairs should be avoided or strictly supervised for the remainder of the day.

I have been informed about the medication(s) that will be used, the routes of administration, and common side effects.

I understand and have been informed that, because of the biological variations of individuals, reactions to the administration of any medication cannot be positively determined in advance. Among the possible, although rare complications may be: allergic reactions, exaggerated effects of the medication causing a deep sedation, and/or a decrease in vital functions(s). It is also possible that the medication may not have the desired sedative effect, (either too much or too little sedation). In the event of any of the hereto mentioned effects it will be up to the discretion of Paul D. Biederman, D.D.S. or Daniel E. Biederman, D.D.S. to modify the treatment regimen according to the patient's physiological and psychological status.

I further understand that following treatment, if any unusual reactions occur I will report them to them to his office as soon as possible, and to the nearest hospital emergency room or my physician if the reaction so requires.
Dr. Paul D. Biederman's after hours emergency phone number is 410-730-3921.
Dr. Daniel E. Biederman's after hours emergency phone number is 410-258-0041.

Other/ alternative methods available to accomplish the dental treatment have been presented to me, along with their potential risks and limitations, including the penitential risk of delaying dental treatment.

I have read and discussed the above with Dr. Paul and/ or Daniel Biederman, and have had all of my questions answered.

I verify that the parent/legal guardian has had an opportunity to be aware before administration of any prescribed medications of the methods and risks of the procedure including but not limited to the use of sedative medications.

_____ _____

Daniel E. Biederman D.D.S. Date Witness Date

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTOOD IT, AGREE WITH THE PROPOSED TRETMENT AND METHOD, AND, WITH WHAT IT SAYS, AND HAVE RECEIVED SATISFACTORY ANSWERS TO ALL QUESTIONS.

_____ _____

Parent/Legal Guardian Date Witness Date

I verify that I have received a copy of this document.

_____ _____

Parent/Legal Guardian Date Witness Date

Kids Dental Center, LLC
Daniel E. Biederman, DDS

410.465.6000
410.740.0606

Pre-Sedation Medical Update

Patient Name: _____
Birthdate: _____

Is your child in good health? □ Yes □ No

Has your child been sick within the last 2 weeks (cold, flu, fever, coughing, congested, nausea/ vomiting, etc)? □ Yes □ No

Please CIRCLE any of the following conditions that affects your child:

- Allergies to Foods
- Allergies to Meds
- Parents smoke
- ADD/ADHD
- Developmental delay
- Psychiatric or emotional disorder
- Reflux/ GERD
- Breathing problems, sleep apnea, Airway Compromise (ie. Large tonsils, asthma)
- Snore, restless, bedwetting, apnea, frequently awaken, nightmare
- Neck circumference, BMI >85%, Tonsils touching (Malampati score), craniofacial anatomy
- Has your child ever been Sedated in the past?
- Recent injury to head or face?
- Cardiorespiratory Disease, shunts
- Blood Disorder
- Kidney or liver disease
- Neuromuscular disease
- Neurologic injury or chronic nerve conditions

***** Is there any medical condition from which the child suffers which is not listed? □ No □ Yes**

In the space provided below, please explain any conditions affecting your child:

_____
_____
_____
_____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold KDC, my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I understand that any omissions of my child's health history could result in adverse affects my child's health during administration of a Sedative medication.

sign

Name of Parent/guardian completing this form:_____

Relationship to patient: □ Mother □ Father □ Other _____

Signature: _____ Date: _____

Signature of Dentist: _____ Date: _____
(Daniel Biederman, D.D.S.)

Note: Any change to the health status of the above patient should be reported to the office as soon as possible.