DR. JOHN N. CONNIFF
DR. LAURIE A. GORMLEY

CONSENT FOR THE USE OF SEDATION FOR PEDIATRIC DENTAL TREATMENT

I _____ as the legally responsible parent/guardian of , give my consent to the use of local anesthetics and sedative drugs as deemed appropriate by the judgment of Dr. Conniff or Dr. Gormley so as to enable him/her to render necessary dental treatment as indicated on the child's examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned treatment.

I have been informed and understand that there is or can be possible complications with drugs or anesthetic agents, including mortality or morbidity.

Dr. Conniff, Dr. Gormley and/or their staff have discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the pre-operative and post-operative instructions. The treatment and sedation and/or anesthesia procedures have been explained to me, to my satisfaction along with possible alternative methods and their advantages and disadvantages.

I have read this consent and understand, to my satisfaction, the procedures to be performed and accept the possible risks. I also understand that the sedation is not 100% successful and that there are some children who will still not allow the treatment to be provided.

Signature of legally responsible parent/guardian _____ _
Date signed _____Address _____ _
Phone number of legal parent/guardian _____ _
Witness _____ _