CONSENT FOR PROTECTIVE IMMOBILIZATION

I, ____________________________ have discussed the use of protective immobilization with my dentist and agree to the use of immobilization in order to complete needed dental care for my child, ____________________________.

I understand the reason my child needs immobilization is the following: (check one)

1. He/she requires immediate diagnosis and/or limited treatment and cannot cooperate, due to a lack of maturity.
2. He/she requires immediate diagnosis and/or limited treatment and cannot cooperate, due to mental or physical disability.
3. Either, my child and/or the dentist and staff would be at risk without the protective use of immobilization.

I understand the benefits of this procedure are:

1. Reduction or elimination of untimely movement.
2. Protection of the child and dental staff from injury.

I understand there are no known risks to the immobilization procedure.

I understand that the alternative management procedures are sedation or general anesthesia, both of which have an increased risk of injury.

Parent/Guardian Signature ____________________________ Date ________________

Doctor Signature ____________________________ Date ________________

Witness Signature ____________________________ Date ________________

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Section Completed Trainee Initial Trainer/Supervisor Initials ________