YOUR CLINIC NAME

STREET ADDRESS
CITY, STATE ZIP
TELEPHONE FAX

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.
3. Facilitate the delivery of quality dental treatment.

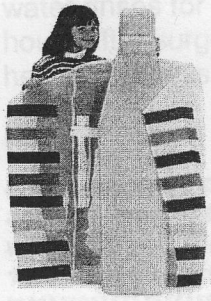
I understand there are no known risks to the immobilization procedure.

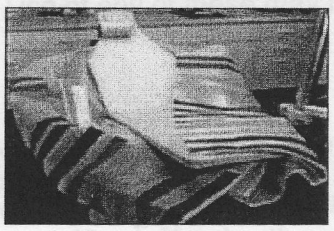
I understand that the alternative management procedures are sedation or general anesthesia, both of which have an increased risk of injury.

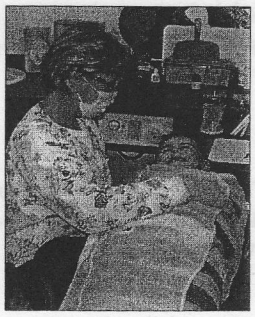
_____ _____
Parent/Guardian Signature Date

_____ _____
Doctor Signature Date

_____ _____
Witness Signature Date







Section Completed **Trainee Initial**_____ **Trainer/Supervisor Initials**_____