



All About Kids Pediatric Dentistry
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Consent for IV Sedation in Absence of Parent/Guardian

** (Authorized Name = the person bringing Patient to Sedation) **

I, _____, the parent/legal guardian of patient _____, with DOB _____, give full permission to _____ (**Authorized Name**) appoint my child to his/her IV sedation appointment scheduled on _____, (**Date of Sedation**) with Dr. Wilson. I have reviewed the attached treatment plan and authorize Dr. Wilson to perform the procedures indicated.

I have also thoroughly read the IV Sedation packet and understand all procedures, medications and post-op instructions to the best of my ability. My child's health history form is also attached. I have reviewed this form and signed this form. I authorize the release of my child's prescriptions to _____ (**Authorized Name**). If there are any changes to the treatment plan, _____ (**Authorized Name**) has my permission to make an informed decision regarding my child's care.

By signing this letter I am agreeing that I have no further questions and that once treatment is complete, Dr. Wilson may release my child to the custody of _____ (**Authorized Name**).

****Please have Authorized Party bring his/her ID to appointment****