

Children's Dentistry of Baytown
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Protective Stabilization Consent

The AAPD (American Academy of Pediatric Dentistry) recognizes that in providing oral health care for our patients, behavior management techniques may be needed during the dental visit. The Protective Stabilization is one of them. Protective Stabilization is rarely used. It consists of gently protecting the patient from movement during a dental procedure while allowing safe completion of the treatment.

I, _____, the parent and or legal guardian of the patient, _____, understand that physical, **ACTIVE STABILIZATION** (can include but not limited to the holding of hands, feet and head by one of our dental team members) and or **PASSIVE IMMOBLILIZATION** (Papoose® board restraint) **MAY BE NEEDED** to facilitate the rendering of the necessary dental treatment. I understand the reason for this recommendation is for the safety and well-being of my child, although the act of restraining him/her may make him/her upset. I understand that restraint will be provided in the most gentle and compassionate manner possible, but that, ultimately, the restraint must aid **Dr. Vega** in providing the dental treatment that I have consented to in the safest manner possible.

It has been discussed with me that if any type of **PROTECTIVE STABILIZATION** needs to be done on my child, a member of the dental team will take me back to be present. Also I understand at this point I can decide to continue on with treatment or abort treatment and discuss other options. If I decide to stop, I will let Dr. Vega finish the procedure she is doing, making sure my child will not be in pain.

I have had an opportunity to ask any questions about the recommended protective stabilization and discussed any concerns that I have with **Dr. Vega** and/or her staff. I also acknowledge reading and reviewing the above consent.

Signature of parent/guardian

Print Name and Relationship to Patient

Date

Witness