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**CONTRIBUTED BY**

**Dr. Skowronski**

**INFORMED CONSENT FORM FOR INFANT ORAL SURGERY**

Prior to completing any oral care on your infant, we require your consent to treat your child. It is the philosophy of this office to provide children with the highest quality of care in a manner which is as pleasant and as safe as possible. During treatment on small infants, it may be necessary for your infant to be swaddled or placed in a similar protective appliance to control undesirable movements. In some instances, there may be a need for the Doctor to numb the surgical area using a small amount of local anesthetic and to provide adequate visibility and access to the surgical areas using a comfortable mouth prop. Older infants may require some type of oral premedication, which if needed, will be discussed prior to having any child sedated. The purpose of all these procedures are to gain and maintain good oral health, primarily at this age, breastfeeding, reducing maternal discomfort and in many instances, future problems that may be associated with lingual and or lip-ties. The Doctor anticipates good results, however, no guarantees as to the results are given. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post-surgical discomfort may be minimal or last as long as a week before our goals are met. Bleeding is always a rare possibility; however, after completing this type of surgery, this office has not experienced any significant problems that would indicate any serious risks of the surgery. Not treating existing dental problems in children may result in breastfeeding problems. Successful breastfeeding is our primary goal for today’s surgery. Parents and guardians should understand recommended procedures, alternative options and anticipated results. All surgery in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this surgery are dependent on parents following carefully all post-operative recommendations for keeping the surgical sites from healing together, seeing their lactation consultant and if indicated a cranial-sacral therapist.

ACKNOWLEDGMENT OF INFORMED CONSENT

I hereby acknowledge that I have been fully informed as to the treatment considerations. I have read and understand this form. I understand the advantages and disadvantages of treatment as well as alternative means of completing these procedures. I understand that my infant will be treated while I remain in the consultation room. The Office has explained to you, the purpose of the surgery through a consultation involving photos and oral discussions and written information. I have been given the opportunity to ask the Doctor all questions I have about the proposed surgical treatment. All questions and concerns have been discussed. I give my free and voluntary, informed consent for treatment to be completed. By signing this consent form, I indicate that I have legal authority to grant this permission. I also agree to pay all fees and have given the Doctor a complete medical history of my child.

(Print Child’s Name)

(Parent’s/Guardian’s Signature) (Today’s Date)

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: During office procedures, photographs or video of interesting cases may be completed. We would like your consent to use these for educational purposes such as lectures of professional articles to advance breastfeeding.

CONSENT TO USE PHOTOS AND VIDEOS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Parent’s/Guardian’s Signature)