



Dear Physicians and Staff,

American Pediatric Sedation Center is a new state of the art office, dedicated to providing pediatric sedation services in a safe and comfortable environment. We have partnered with the American Pediatric Dental Group to offer our services exclusively to their patients. Our services are offered under the care of an experienced, Board-Certified Medical Anesthesiologist.

Sedation dentistry is required when traditional approaches to treatment are insufficient to calm or soothe an extremely apprehensive or fearful child. Sedation in the office may include oral, intravenous, intramuscular, and inhaled nitrous oxide. This is a better alternative for pediatric patients who are **healthy (ASA I and ASA II)** and do not have to undergo general anesthesia in the hospital setting.

In order to ensure that the patient is a candidate for sedation dentistry in the office, I need your cooperation in obtaining a thorough medical clearance. The safety of our patients is our number one priority! Therefore, we are now having all of our pediatric patients obtain a medical clearance prior to dental procedures which may involve sedation.

For sedation in the clinic setting, the **medical clearance is valid for 30 days**. The information that I ascertain from the medical clearance *includes but is not limited to* the following:

- **Any potential airway issues such as enlarged tonsils, adenoids, recent URI, or OSA**
- **Congenital disorders**
- **Cardiac conditions**

On the day of the sedation appointment, we will obtain vitals such as: weight, blood pressure, and temperature. The pre-operation exam will rule out any acute cold and flu like symptoms and NPO restrictions.

We would like to thank you in advance for completing this form in its entirety so that my team and I can review it prior to administering any form of sedation. Together, we know we can continue to keep our patients safe and healthy at all times! Should you have any further questions or have pediatric patients who can benefit from our dental sedation services, please don't hesitate to contact our office at 954-417-1330. You may also email us at sedation@americanpediatricdentalgroup.com or fax us at 954-637-1955.

Sincerely,

F.Huda, MD
Faisal Huda, MD
Board Certified Anesthesiologist

W.Pena, DMD
William Peña, DMD
Board Certified Pediatric Dentist

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Pediatric Sedation Medical Clearance Form

Patient Name (Last, First) _____ Date of Birth: _____
 Patient Phone Number (Home): _____ (Cellular): _____
 Date of Medical Clearance: _____ Scheduled Date of Procedure: _____

Pediatricians Please Complete ENTIRE Form Below Thoroughly:

List of Allergies:	Type of Reaction	Current Medications:	Dose (mg)	Frequency

Please check ALL Pertinent Medical Conditions – Conditions in BOLD are specific to sedation		
<input type="checkbox"/> Recent URI/Cough/Cold/Flu <input type="checkbox"/> Enlarged Tonsils/Adenoids <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Obesity <input type="checkbox"/> Cardiac anomalies (PDA/VSD/ASD/PFO) <input type="checkbox"/> Cardiac murmur <input type="checkbox"/> Asthma <input type="checkbox"/> Airway/Trachea anomaly	<input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Liver Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Epilepsy/Hx of Seizures <input type="checkbox"/> Hx of VP Shunts <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Autism <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Down’s Syndrome <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Failure to thrive/underweight

PHYSICAL EXAM:

Systems	Findings:	Vital Signs	
HEENT:		Height:	
Does patient have enlarged tonsils and/or adenoids? YES or NO		Weight (kg):	
Cardiac:		Is patient overweight or obese? YES or NO	
Lungs:		Blood Pressure:	
Abdomen:		Heart Rate:	
Extremities:		Temperature:	
Neuro/Psych:		Date of Menarche (Females): _____	

IS ANTIBIOTIC PROPHYLAXIS RECOMMENDED? (CIRCLE ONE) YES or NO

IS THIS PATIENT MEDICALLY CLEAR FOR SEDATION? (CIRCLE ONE) YES or NO

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PHYSICIAN NAME	PHYSICIAN SIGNATURE	DATE
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