Dear Physicians and Staff,

American Pediatric Sedation Center is a state of the art office, dedicated to providing pediatric sedation services in a safe and comfortable environment. We have partnered with 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 non-pharmacologic approaches to treatment are insufficient to calm or soothe an extremely apprehensive or fearful child. The sedation technique at our center 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 requiring sedation.

For sedation at our center, 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 and/or history of any surgeries**

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 **APDGSedation@d4c.com** or fax us at 954-637-1955. For more information, please visit our website at **www.AmericanPediatricSedation.com.**

Sincerely,

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

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

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Phone: 954-417-1330 Fax: 954-637-1955
**Email: APDGSedation@d4c.com; Website: www.AmericanPediatricSedation.com**

# 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:

| **List of Allergies:** | **Type of Reaction** |
|---|---|
| | |
| **History of Surgeries:** | |

| **Current Medications:** | **Dose (mg)** | **Frequency** |
|---|---|---|
| | | |
| | | |

| **Please check ALL Pertinent Medical Conditions – Conditions in SHADED area are specific to sedation** | | |
|---|---|---|
| ☐ **Recent URI/Cough/Cold/Flu** | ☐ Diabetes Type I | ☐ Epilepsy/Hx of Seizures |
| ☐ **Enlarged Tonsils/Adenoids** | ☐ Diabetes Type II | ☐ Hx of VP Shunts |
| ☐ **Obstructive sleep apnea** | ☐ Thyroid Problems | ☐ Hydrocephalus |
| ☐ **Obesity** | ☐ Liver Disease | ☐ Autism |
| ☐ Cardiac anomalies (PDA/VSD/ASD/PFO) | ☐ Kidney Disease | ☐ Developmental Delays |
| ☐ Cardiac murmur | ☐ Anemia | ☐ Down's Syndrome |
| ☐ Asthma | ☐ Sickle Cell Disease | ☐ Cerebral Palsy |
| ☐ Airway/Trachea anomaly | ☐ Hemophilia | ☐ ADD/ADHD |
| | ☐ Bleeding/Clotting Disorders | ☐ 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**

| | | |
|---|---|---|
| | | |
| **PHYSICIAN NAME** | **PHYSICIAN SIGNATURE** | **DATE** |

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