CONSENT FOR ANESTHESIA ADMINISTRATION

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I understand that I will be receiving Anesthesia and my Anesthesiologist will use their best judgement in my care providing this anesthetic. Anesthesia risks and dangers are rare but can be life threatening. Risks range from minor irritation at the insertion site of the Intravenous insertion all the way up to death. Although uncommon, adverse drug reactions, damage to the throat, teeth, vocal cords, or dental work, do rarely occur. I am aware that the practice of Anesthesia and Medicine is not an exact science and that no guarantee or assurance can be made as to the results that may occur.

I have read the above, my questions have been answered, and I consent to the Administration of Anesthesia.

_____ _____/_____/_____

Name of Parent/Guardian (Please Print Full Name) Date

_____

Signature of Parent/Guardian

_____

Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

_____

Witness Signature & Print Full Name