The Ohio State College of Dentistry Continuing Dental Education
Nitrous Oxide Sedation Course Participant
Informed Consent and Release Statement

I, the undersigned, hereby acknowledge that I have voluntarily agreed to participate in the Continuing Education Course on Nitrous Oxide Sedation provided for the Dental Hygienist and Dental Assistant Certification at The Ohio State University College of Dentistry (OSU CoD). I have completely and accurately revealed and described my previous and current medical and dental conditions on my health history form, which is hereby incorporated by reference.

Upon registration for the combined academic and practical course on nitrous oxide, I understand that as a Registered Dental Hygienist I will be administering and receiving nitrous oxide and as a Dental Assistant I may receive nitrous oxide as a condition of course completion. The hands-on session will take place in the clinical facilities provided by the OSU CoD, with direct faculty supervision, and according to applicable laws, regulations and safety standards. I understand that if I have any health conditions that may preclude me from receiving nitrous oxide I must disclose these and I will not be able to participate in the training unless I provide documentation from my physician that my participation is safe. Some of the principle contraindications include participants with bowel obstruction, pneumothorax, middle ear or sinus disease. Nitrous oxide should also not be used on any patient who has been scuba diving within the preceding 24 hours or in persons with disturbed psychiatric conditions. There are also clinical cautions in place for participants with decreased levels of consciousness. This continuing education program also excludes all participants who are pregnant or possibly pregnant unless documentation from a physician is provided.

I am aware that receiving Nitrous Oxide and conscious sedation via the use of Nitrous Oxide carries certain risks and complications that include, but are not limited to: excessive perspiration, headache, dizziness, nausea and vomiting.

My signature confirms that I am willing to undertake the risks of giving and/or receiving nitrous oxide sedation.

I hereby, knowingly, freely, and voluntarily release, and hold harmless, The Ohio State College of Dentistry and their agents, employees, servants, students and assignees from any and all liability, claims, demands or causes of action whatsoever, including liability for negligence, arising out of any damage or injury which I might suffer in the course of, or related to, participation in the Nitrous Oxide Sedation for the Dental Hygienist and Dental Assistant Certification Training CE Program at The Ohio State College of Dentistry.

Participant Name (Print)_____________________________________________________
Participant Signature____________________________________________________ Date ___________________
PATIENT MEDICAL/DENTAL HISTORY

Patient Name: ___________________________       Today’s Date: ____________________

(First)     (Last)

MEDICAL HISTORY:

Do you have, or have you had any of the following?
Circle One

1. High Blood Pressure            Y   N
2. Angina / Chest Pain           Y   N
3. Cardiac Pacemaker             Y   N
4. Heart Attack                  Y   N
5. Heart Disease                 Y   N
6. Heart Murmur/ Mitral Valve Prolapse  Y   N
7. Stroke                       Y   N
8. Faintness/ Seizures           Y   N
9. Respiratory/ Lung Condition   Y   N
10. Shortness of Breath         Y   N
11. Radiation Therapy           Y   N
12. Cancer                      Y   N
13. Do you have any bone diseases?   Y   N
   (Osteoporosis, Paget’s disease, Cancer w/ Spread to the bones breast, lung, liver, prostate, or kidney)
   Multiple Myeloma or other bone conditions?
14. Are you taking any Bisphosphonate Medications? Y   N
15. Tuberculosis                     Y   N
16. Thyroid Problems               Y    N
17. Immune Disorder/ HIV          Y   N
18. Glaucoma                        Y   N
19. Diabetes                       Y   N
20. Kidney Disease                 Y   N
21. Liver Disease/ Hepatitis       Y   N
22. Stomach Problems              Y   N
23. Arthritis                      Y   N
24. Recent Weight Gain or Loss?    Y   N
25. Joint Replacement or Prosthetic Implant Y   N
26. Are you currently nursing or pregnant? Y   N
27. Allergies to medications or latex?   Y   N
   (Please list)_____________________
28. Use tobacco products          Y   N
29. Have you taken any diet medications or products? Y   N
30. Prolonged bleeding            Y   N
31. Hearing problems/ hearing aids Y   N

Please list the name of your family physician: or Check here if no Primary Physician  □

Name of Physician: ____________________________________________
Street Address: __________________________________________________
City_________________ State ______ Zip______ Telephone #________________

32. Date of Last Medical Exam __________________________________________________________________

33. Do you have or have you ever had any disease, condition or problem not listed here? Y   N

34. Have you ever been told you need to take an antibiotic prior to dental treatment? Y   N

35. Are you currently under the care of a physician (M.D., D.O.)? Y   N

36. Have you had trouble associated with previous dental treatment? Y   N

37. When was your last dental check-up and/or cleaning? __________________________________________

38. Are you currently taking any drugs, medications, or supplements? Please list below Y   N
   (Medications such as antibiotics, heart medicine, birth control pills, aspirin therapy, vitamins, herbal supplements)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose/ Frequency</th>
<th>Reason for Taking</th>
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I certify that the above information is complete and accurate to the best of my knowledge:

Signature: ___________________________ Relationship to Patient: Self Parent Guardian

To be completed by your dentist- Summary of Patient’s Medical Status:

________________________________________________________________________________________

Dentist’s Signature: ___________________________ Date: ____________________
In Case of Emergency, Please Notify

Name: ____________________________________________

Relationship: ______________________________________

Home Phone: ____________________________

Cell Phone: ____________________________

Work/Other Phone: _______________________

Address: _______________________________________

City: _________________________________________

State: ____________ Zip: ____________