Kingdom of Saudi Arabia
Ministry of Higher Education
Princess Nourah bint Abdulrahman University
(048)
College of Dentistry

المملكة العربية السعودية
وزارة التعليم العالي
جامعة الأميرة نورة بنت عبدالرحمن
(٠٤٨)
كلية طب الأسنان

Parental Agreement to Investigation or Treatment for Children/Young Patients

Patient Details or Label

This treatment/procedure information document prepared for

Family name	[redacted]
First name	[redacted]
Date of birth	24.05.2017
Age	5 months
Gender	F
File number	[redacted]
Responsible health professional	Dr. Ashwag Aloyouny
Job title	Senior Registrar- Oral Medicine specialist
Special requirements	the patient needs to be with parents (infant)

To be retained in patient's notes

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)
Extra and Intra-oral examination, taking swab for PCR and further lab investigation perscribing proper medications.

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits: Diagnosing the oral and perioral lesions

Unavoidable, serious or frequently occurring risks bleeding, discomfort

☐ Blood transfusion _____

☐ Other procedure (please specify) _____

I acknowledge that I have been provided a treatment/procedure information document prepared for my child. This document outlines the general treatment considerations, potential risks and hazards associated with my child's treatment. I, also, understand that there may be potential hazards and risks not described in the treatment/procedure information document. I have had the opportunity to discuss and clarify treatment considerations and risks with **Dr. Ashwag Aloyouny**. The prescribed treatment was explained to me on 19.10.2017. I authorized student(s), resident(s) and/or faculty of University school of Dentistry to provide the outlined treatment. I further understand that, like the other healing arts, the practice of dentistry is not an exact science and that, therefore, not all complications can be predicted, and treatment results cannot be guaranteed.
Any extra procedures which may become necessary during the procedure.

Patient's Bill of Rights
The students, faculty, and staff of Exam Group School of Dentistry strive to provide high quality treatment/procedure in a patient-friendly atmosphere. As our patient, you have a right to the following:

- Comprehensive treatment that meets professional standards of care.
- Clear explanation of recommended and alternative treatment options, the risk of such treatment options and the risks of no care.
- Current information about the status of your oral/dental health and progress of care.
- Accurate information about costs prior to proposed treatment.
- Treatment with respect, consideration, and confidentiality.
- The right to ask questions about your oral/dental care at any time.
- Access to a patient representative for assistance
- Adequate information as needed to be able to give consent to proposed procedures
- Confidentiality regarding your medical conditions, oral health and records.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient and his or her parents.

☐ The following leaflet/tape has been provided

This procedure will involve:
☐ General an[redacted]sia ☐ Local anesthesia ☐ Sedation ☑ None

Signed [redacted] Date: 19.10.2017

Name (PRINT): Dr. Ashwag Aloyouny

Job title: Senior Registrar- Oral Medicine specialist

Contact details (if child/parent wishes to discuss options later) # 41024

Statement of interpreter (where appropriate)
I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.
Signed_____ Date_____

Name (PRINT) _____

Statement of parent/person with 'parental responsibility'
Please read this form carefully. If the procedure has been planned in advance, you should have had the risks and benefits and any alternative treatments described to you. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

☐ **I agree** to the procedure or course of treatment described on this form and **I confirm** that I have 'parental responsibility' for this child.

☐ **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

☐ **I understand** that my child and I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anesthesia.)

☐ **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

☐ **I have been told** about additional procedures, which may become necessary during my child's treatment.
I have listed below any procedures, which **I do not wish to be carried out** without further discussion.

Signature [redacted] Date: 19.10.2017

Name (PRINT) [redacted] Relationship to child [redacted]

Child's agreement to treatment (if child wishes to sign)
I agree to have the treatment I have been told about.
Name_____ Signature_____

Date_____

OR, I THE PATIENT/PARENT REFUSED INFORMATION ABOUT TREATMENT

Signature _____ Date: _____

Name (PRINT) _____ Relationship to child _____

Confirmation of consent (to be completed by a health professional when the child is admitted for the procedure, if the parent/child has signed the form in advance)
On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish the procedure to go ahead.

Signed_____ Date_____

Name (PRINT)_____ Job title _____

Important notes: (tick if applicable)
☐ See also advance directive/living will
☐ Parent has withdrawn consent (ask parent to sign/date here) _____

Agreement for research purpose:

I, (Mother of [redacted] authorizes dentist/oral medicine specialist to take photographs, radiographs, dental impressions or any necessary diagnostic aids to make a complete diagnosis for the patient.
I consent to allow my medical information, photographs, x-rays to be used for dental records, oral/dental health research, and oral/dental health education including lectures, and professional publications. I, also, understand that my identity will be kept confidential.
Signed_____ Date 19.10.2017

Name (PRINT [redacted]

Dental/Oral medicine consent form

I, (Mother of) [redacted] authorizes dentist/oral medicine specialist to take photographs, radiographs, dental impressions or any necessary diagnostic aids to make a complete diagnosis for the patient.

I authorize dentist/oral medicine specialist to perform all recommended treatment mutually agreed upon by me and to use the appropriate therapy indicated for my condition.

I consent to allow my medical information, photographs, x-rays to be used for dental records, dental research, and dental education including lectures, and professional publications. I, also, understand that my identity will be kept confidential.

Patient nam [redacted]

Guardian na

Signature:

Dr. Ashwag Aloyouny
Oral Medicine

Date: 19. 10.2017

Authorization for Publication of Case study

I, (Mother [redacted] give Dr. Ashwag Aloyouny and her team at Princess Nourah Bint Abdulrahman University, College of Dentistry, permission to publish, reproduce, and distribute, the attached Case Study, regarding *Oral and Perioral Herpes Simplex Virus Infection Type I in A Five-Month-Old Infant: A case report and discussion*. I am aware that the case study does NOT mention my name or address, but it does reflect my medical care, age, gender, and medical history.

I have been told that the authors currently plan to submit the case study for publication in a medical journal for educational purposes.

I will not be paid in any manner for the use of the case study, as described above. I will not receive any royalties or other compensation in connection with any such publication or use.

I am not required to sign this form, and I may refuse to do so. My medical treatment and payment for healthcare will not be affected by whether or not I sign this document.

I may withdraw this authorization for any future sharing at any time by notifying my attending physician in writing, but my withdrawal will not affect the information that has already ben shared or published. This authorization has no expiration date.

Patient name [redacted]

Guardian na

Signature:

Dr. Ashwag A
Oral Medicin

Date: 19. 10.2017