Ear Piercing Consent Form

Patient name: _____

Date of birth: _____

Please initial below to indicate consent:

____ I understand that fees for ear piercing will not be filed with my insurance. All payments for this service are due in full at the time of the visit.

____ I understand that my child's ears will be pierced with pre-sterilized, single-use cartridges with hypoallergenic ear-studs.

____ I understand that if my child is taking blood thinning medications, antibiotics, steroids or antihistamines that ear piercing may carry a greater risk.

____ I attest that to the best of my knowledge, my child does not have high blood pressure, epilepsy, hemophilia or other bleeding disorders, a heart condition, or is pregnant.

____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches and abscess drainage. Despite all precautions taken by Tetteh Pediatric Health and my proper following of aftercare instructions, the potential for infection still exists. There is also potential that one of the following complications may occur as a result of ear piercing:

Persistent redness	Swelling	Drainage	Bleeding
Embedded clasp	Local infection	Cellulitis	Blood poisoning
Keloids	Cauliflower ear	Pressure sore	Traumatic injury

I will contact Tetteh Pediatric Health if any of these occur or are suspected to have occurred.

____ I have read and understand the Aftercare Instructions and have received a copy for my reference. I understand that after care is the sole responsibility of the patient/parent/caregiver once leaving the office.

____ I have agreed to this ear-piercing procedure and am fully aware of the potential risks and complications.

I have read and understand all of the items listed above and agree to their terms. If the patient is a minor, then the undersigned certificates to Tetteh Pediatric Health that the undersigned is the parent or legal guardian of the minor patient named above.

Signature of Patient or Parent/Legal Guardian: _____

Name of Parent/Legal Guardian: _____

Relationship to patient: _____