Thomasville-Archdale/Trinity Pediatrics

Consent for Ear Piercing

Patient Name _____ **Date of Birth** _____

PLEASE INITIAL FOR CONSENT:

_____ I understand that fees for ear piercing will not be filed against any insurance. All payments for this service are due at the time of the visit.

_____ I understand that my child's ears will be pierced with pre−sterilized, single use, medical grade plastic or titanium earrings.

_____ I acknowledge that if my child has a bleeding disorder, diabetes, high blood pressure, immune disorder, heart condition, allergies or a skin disorder, then ear piercing may carry a greater risk for my child. My child's pediatrician and I have discussed the risks and benefits of ear piercing with these medical conditions, prior to the procedure.

_____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches or abscess drainage. Despite all precautions that are taken by Thomasville-Archdale/Trinity Pediatrics and my proper aftercare treatment, the potential for infection still exists. There is also the potential that one of the following complications may occur as a result of ear piercing:

Persistent redness

Swelling

Drainage from piercing

Bleeding from piercing

Embedded clasp

Local wound infection/cellulitis

Bacterial infection of the blood (septicemia)

Abnormal healing of the ear such as keloid scarring or cauliflower ear

Pressure sore

Traumatic injury

**Please contact Thomasville-Archdale/Trinity Pediatrics if you experience any of these symptoms.

_____ I have read and understand the AFTER CARE INSTRUCTIONS and have received a copy for my reference. Aftercare of piercing is the responsibility of the parent or patient, once they leave the office.

_____ I agree that if at any time, it is deemed unsafe for my child or the medical staff to continue with the procedure, then the procedure will be stopped and potentially rescheduled for another time.

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

I have read and understand all of the items listed above and I agree to their terms. By signing this document, I certify to Thomasville-Archdale/Trinity Pediatrics that I am the parent or legal guardian of the minor patient named above or I am eighteen years or older and able to consent for my own procedures.

Signature: _____ **Date** _____

Print Name: _____

Relationship to Patient: _____ ☐ **Self**

Witness Signature: _____ **Date**: _____