TREASURE COAST PEDIATRICS
HEALTHY KIDS, HAPPY PARENTS

Treasure Coast Pediatrics: Ear Piercing Consent Form

Patient name _____ DOB _____

Initial below to indicate consent:

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

____ I understand that I/my child's ears will be pierced with pre-sterilized surgical steel earings.

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

___ I acknowledge that if I/my child is diabetic, immune- compromised, have high blood pressure, am pregnant, have epilepsy, have hemophilia or other bleeding disorders, or have a heart condition that ear piercing may carry a greater risk for me.

____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches and abscess drainage. Despite all precautions taken by Treasure Coast Pediatrics 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, or traumatic injury.** I will contact my pediatrician if any of these occur or are suspected to have occurred.

___ I agree to this ear piercing procedure, and fully aware of the potential risks and complications.

___ I read and understand the Aftercare Instructions and have received a copy for my reference.

___ Aftercare of piercing is the responsability of the patient or parent once they leave the office.

the office.

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 certifies to Treasure Coast Pediatrics that he/she is the parent or legal guardian of the minor patient named above.

Signature: _____

Print name: _____

Relationship to patient: _____