CONSENT FOR EAR PIERCING

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Patient Name: ___________________________________ DOB: _____________________

I, ____________________, give permission for ___________________ to have his/her ears pierced.

I understand that my child's ears will be pierced using the Coren Preloaded ear pierce system using hypoallergenic, surgical stainless steel earrings.

I am aware that if my child has a bleeding disorder, high blood pressure, diabetes, immune disorder, heart condition, allergies or skin disorder, that piercing may carry a greater risk.

I am aware that ear piercing is a minor surgical procedure similar to stitches with some risks including:

- Persistent Redness
- Swelling
- Drainage or bleeding from piercing
- Infection/Cellulitis
- Abnormal healing of ear such as keloid scarring
- Traumatic Injury
- Embedded Clasp

I understand that my child must be at least 6 months of age and has had 2 doses of DTaP prior to this procedure.

I have read and understood the After Care Instructions provided by Caring Hands Pediatrics and have a copy for my reference.

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

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

______I have been given the opportunity to view the proposed piercing location on the earlobes and agree with the placement of the earrings.

I have read and understand the above and agree to this procedure.

Signature ____
Relationship to Patient______________________________
Date____