Wildflower Pediatrics, PA
11609 Anderson Mill Road
Austin, Texas 78750

EAR PIERCING CONSENT FORM

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 visit.

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

____ I acknowledge that if my child is taking blood-thinning medications, antibiotics, is a diabetic, has a history of infection or any other medical problems, that ear piercing may carry a greater risk for my child.

____ 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 Wildflower Pediatrics and my proper following of aftercare, the potential for infections exists. There is also the potential that one of the following complications may occur as a result of ear piercing

____ I acknowledge that ear piercing may cause the following adverse events and I hereby release Wildflower Pediatrics from any liability due to the following adverse events:

Persistent Redness	Cellulitis
Swelling	Septicemia
Drainage	Keloids
Bleeding	Cauliflower Ear
Embedded Clasp/Earring	Pressure Sore
Local Infection	Traumatic Injury

*You should contact the practice if your child experiences any of these symptoms.

____ I have read and understand the AFTER-CARE INSTRUCTIONS and have received a copy for my reference. I understand that after-care is solely my responsibility and that Wildflower Pediatrics will not monitor it.

____ 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 certifies to Wildflower Pediatrics that the undersigned is the parent or legal guardian of the minor patient named above.

Signature: _____ Date:_____

Print Name: _____

Relationship to Patient: _____