Sunny Pediatrics

RELEASE FORM/ CONSENT TO EAR PIERCING

I AGREE THAT I GIVE SUNNY PEDIATRICS MY CONSENT TO PERFORM EAR PIERCING. I HAVE READ AND UNDERSTAND ALL OF THE AFTER CARE INSTRUCTIONS. I FULLY UNDERSTAND THAT THESE RISKS, KNOWN AND UNKOWN, CAN LEAD TO INJURY, INCLUDING BUT NOT LIMITED TO INFECTION, SCARING AND KELOIDING, ALLERGIC REACTIONS TO JEWLERY, LATEX GLOVES, AND/OR SOAP. HAVING BEEN INFORMED OF THE POTENTIAL RISKS ASSOCIATED WITH GETTING A PIERCING, I STILL WISH TO PROCEED WITH THE PIERCING AND I FREELY ACCEPT AND EXPRESSLY ASSUME ANY AND ALL OF THE RISKS THAT MAY ARISE FROM THE PIERCING.

I AGREE THAT SUNNY PEDIATRICS GAVE ME THE FULL OPPURTUNITY TO ASK ANY AND ALL QUESTIONS ABOUT THE PIERCING PROCEDURE AND THE STAFF HAS ANSWERED THESE QUESTIONS TO MY TOTAL SATISFACTION.

I ACKNOLWEDLGE THAT THE BELOW-NAMED PATIENT IS NOT SUFFERING FROM DIABETES, ALLERGIES, HEART CONDITIONS, OR ANY OTHER MEDICAL OR SKIN CONDITION THAT MAY INTERFERE WITH THE PROCEDURE OR HEALING OF THE PIERCING. I ACKNOWLEDGE THERE IS NO DISCOLORATION, SWELLING, LUMPS, OR SIGNS OF IRRITATION OF THE EAR LOBES OR CARTILAGE.

I REALIZE THE IMPORTANCE OF PROPER CARE IN PERMITTING THE EARS TO HEAL WITHOUT INFECTION. I PROMISE TO FOLLOW EACH STEP OF THE INSTRUCTIONS ON THE EAR CARE SHEET THAT HAS BEEN PROVIDED. I ACKNOWLEDGE THE IMPORTANCE OF THESE INSTRUCTIONS IN MAINTAINING HEALTHY EARS.

I ACKNOWLEDGE THE PIERCING WILL RESULT IN A PERMANENT CHANGE TO THE PATIENT'S APPEARANCE AND THAT THE SKIN MAY NOT BE RESTORED TO ITS PRE-PIERCING CONDITION EVEN AFTER ITS REMOVAL.

YOU MUST BE 18 YEARS OR OLDER TO HAVE YOUR EARS PIERCED WITHOUT A PARENTAL GAURDIAN'S CONSENT. YOUR SIGNTURE AT THE BOTTOM INDICATES YOU ARE OVER 18, OR THAT YOU ARE THE PARENT/LEGAL GAURDIAN GIVING CONSENT.

________ I AM THE CHILD'S PARENT OR LEGAL GAURDIAN AND I CONSENT HAVING THE BELOW LISTED CHILD'S EARS PIERCED.

________ I AM LEGALLY COMPETENT AND I CONSENT TO HAVING MY EARS PIERCED.

PATIENT NAME ______________________________ DATE OF BIRTH ______________

ADDRESS ______________________ CITY ____________ STATE ______ ZIP __________

TELEPHONE ______________________________ PROCEDURE DATE ______________

PATIENT'S SIGNATURE ______________________________ DATE ______________

PRINT NAME ______________________________

SIGNATURE OF PARENT OR GAURDIAN IF PARTICIPANT IS A MINOR

GAURDIANS SIGNATURE ______________________________ RELATION ______________

PRINT NAME ______________________________