Northeast Pediatric Clinic
Consent to Ear Piercing

Section 1 – to be completed by NEPC staff:

Date __________ NEPC provider signature ______________________________

Ear Lobe only: both _____ left _____ right _____

Photo ID of: patient if 18 years or older ___ or parent/ legal guardian__________
__ driver's license __ state/gov. ID __military ID __passport

ID number: _____________________Name on ID: _______________________

Relationship to customer: ____

Section 2 – to be completed by customer or parent/legal guardian if customer a minor.

Name of customer ____________________________ DOB __________________

Address ____

Age _____ customer must be at least 8 years old

Please initial the following:

___ I understand that my ears will be pierced with pre-sterilized, single use ear piercing earrings.
___I acknowledge that if I am taking blood-thinning medications, antibiotics, am diabetic, pregnant, have a history of infection or any other medical problems, that ear piercing may carry a greater risk for me.
___I understand that, despite NEPC's best efforts and my proper following of aftercare, the potential for infection exists. Improper after care or hygiene, metal sensitivity, or other causes my increase the risk of infection. Ear piercing may result in the formation of cysts or keloids.
___I have read, and understand the AFTER CARE PROCEDURES and have received a copy for my reference. I understand that after care is solely my responsibility and that NEPC will not monitor it.
___I have agreed to this ear piercing procedure, and am fully aware of the potential risks and complications.

Print Name ____

Signature and date: ____

If under 18 years old, parent or legal guardian signature is required.

Original consent will be kept on file at NEPC, a copy will be given to the customer.