DELAWARE MODERN PEDIATRICS, P.A.

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RELEASE FORM/CONSENT TO EAR PIERCING

Child's Name _____ **Date of Birth** _____ **Today's Date** _____

Parent's Name _____ **Provider performing piercing:** _____

Ear Lobe: **Both** _____ **Left** _____ **Right** _____ **Earring size** _____

I consent that I give Delaware Modern Pediatrics, P.A. my consent to perform earlobe piercing. I have read and understand all of the after care instructions.

I acknowledge that the above-named child is not suffering from diabetes, allergies, or discoloration, swelling, lumps, or signs of irritation of the ear lobes or cartilage. I understand that these studs are not designed for nose piercing.

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 INSTRUCTIONS sheet that has been provided. I acknowledge the importance of these instructions in maintaining healthy ears.

You must be 18 years or older to have your ears pierced without your parents consent. Your signature at the bottom indicates that you are over 18, or that you are the parent/legal guardian giving consent.

_____ I am the child's parent or legal guardian and I consent to having the above-named child's ears pierced.

_____ I am legally competent and I consent to having my ears pierced.

_____ _____
Signature *Date*