

Aasha Pediatrics, Inc.

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San Jose, CA 95121
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Meena Sathappan, MD

CONSENT TO EAR PIERCING

Child's Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ - _____

D. O. B. of customer ____ / ____ / _____

- If your child is under 3 months of age, your infant must have their first DPT inoculation.
- I understand that my child's ears will be pierced with pre-sterilized, single-use ear piercing studs that are packaged in sealed container.
- The undersigned, acknowledge that I am aware that the ear piercing may carry some risks. These risk include, but are not limited to, infection, metal sensitivity, allergic reaction, inflammation, embedding, scarring, fainting and other complications.
- I have read, and understand the AFTER CARE PROCEDURES and have received a copy for my after care references.
- I have agreed to this ear piercing procedure for my child, and I am fully aware of the potential risks and complications.

Parent/ Legal Guardian Signature _____ / ____ / _____

Print Name

Witness Signature _____ / ____ / _____

Print Name