Medical Ear Piercing

Today's Date: _______________

Patient's Name: __________________________ Date of Birth: _______________

Payment Received Credit Card Check Cash

Verification of Vaccines: Child must be up to date on all vaccinations
Adults must have record of at least 2 tetanus vaccines

Earring Choices

(Please initial beside your selection)

Medical Plastic Round Crystal _____

Medical Plastic Round Aquamarine _____

Medical Plastic Daisy Crystal _____

Medical Plastic Round Rose _____

Medical Plastic Round Violet _____

Medical Plastic Daisy Rose _____

Placement Approved by Parent: ____________________________________

Completed By: ____

Office Manager Approval: ____