MARYMOUNT UNIVERSITY STUDENT HEALTH CENTER
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Informed Consent for Ear Irrigation/Ear Wax Removal

This disclosure is intended to inform you about the risks associated with Ear Irrigation/Ear Wax Removal so that you may make an informed decision as to whether to give your consent to the procedure.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I acknowledge that the procedure proposed to treat my condition is Ear Irrigation/Ear Wax Removal.

I understand that this medical procedure involves risks, including, but not limited to, tympanic membrane perforation, pain, vertigo, external ear canal trauma, otitis externa, audio-vestibular loss, skin laceration and pain, skin irritation, discomfort, mansient hearing loss, dizziness, or infection. I also understand that each person reacts differently to Ear Irrigation/Ear Wax Removal, therefore, the results of this medical procedure may vary.

ACKNOWLEDGEMENT AND CONSENT

By signing below, I confirm that:

- I understand the procedure;
- consent to, and accept the risk of, the procedure;
- have had the opportunity to ask questions and these questions have been answered to my satisfaction; and
- release Marymount University Student Health Center from all liabilities associated with the above indicated procedure.

_____ _____ / _____ / _____
Patient's Signature **Date**

_____ _____ / _____ / _____
Patient's Name (Printed) **Patient's Date of Birth**

If signed by anyone other than the patient, check the box that describes the relationship to the patient:

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Other: _____

TO BE COMPLETED BY PRACTITIONER

I have discussed the procedure with the patient (or the patient's authorized decision-maker) and answered his/her questions. The patient (or decision-maker) consented to the procedure.

_____ _____ / _____ / _____
Practicioner's Signature **Date**