MASTER PIERCE BODY PIERCING STANDARD RELEASE FORM

Master Pierce
Professional piercing

Name: _____

Date: _____/_____/_____Address:_____ City:_____
State:_____ Zip:_____Phone:_____ Date of Birth: _____/_____/_____ Race: _____ Sex: _____
Emergency Contact:_____ Phone:_____ Addre
ss:_____Physician*:_____
Phone: _____ Address:_____
*You may choose to initial below indicating your choice to designate the Wellington Regional Hospital as your physician. _____ (Client Initials) Wellington Regional Hospital - 561-798-8500 - Wellington, FL

Bleeding Disorders: Yes ____ No ____ If Yes List: _____
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Allergies/ Skin Conditions: (i.e. Iodine, topical solutions, medications, latex, etc.) _____

I am at least 18 years. I do not have a heart condition. I am not diabetic. I haven't had hepatitis within the last year. I am not a hemophiliac (bleeder). I do not have epilepsy. I am not under the influence of drug or alcohol. To my knowledge, I do not have a physical, mental, or medical impairment or disability, which might affect my well being as a direct or indirect result of my decision to have any piercing done at this time. Being of sound mind and body, I hereby release any and all persons representing Master Pierce from all responsibility. I accept any and all responsibility for myself, for any and all consequences that might arise from my decision to have any piercing done by Master Pierce. I agree not to bring suit against Master Pierce in connection with any and all damages, claims, demands, rights, and causes of action of whatever kind or nature, based upon injuries or property damage to, or death of myself, or any other persons arising from my decision to have a piercing done at this time, whether or not caused by any negligence of Master Pierce. I agree to pay any and all damages and injuries to any and all persons and property belonging to Master Pierce, or any other persons to whom Master Pierce may become liable contractually or by operation of law, caused by, or resulting from my decision to have any piercing done by Master Pierce. I agree to pay the reasonable attorney's fees and costs arising from any legal action against Master Pierce brought by myself, my agents or assigns. I agree to leave the premises of Master Pierce, or any other establishment where Master Pierce is engaged in business, promptly upon request, for any reason whatsoever, by any agent or employee of Master Pierce. I agree that those waivers also pertain to and are designed to protect any and all es-tablishments where Master Pierce conducts business. I represent and warrant to Master Pierce that the above information is true and correct. I have advised the Piercer of any allergies to metals, latex gloves, soaps and medications. I acknowl-edge it is not reasonably possible for the Piercer to determine whether I might have and allergic reaction to the piercing or process involved in the piercing and further acknowledge that such reaction is possible. I have had the aftercare instruc-tions explained to me. I understand all the aftercare instructions as they were explained. I have been given a copy of my aftercare instructions. I agree to follow all instructions concerning the care of my piercing while it is healing. I acknowledge infection is always possible as a result of obtaining a piercing. I realize that my pierce is being done in a sterile environment with sterile instruments, sterilized in an "Autoclave". I accept any and all responsibility myself for any consequences that might arise from my decision to have any piercing work done at Master Pierce.

Signed_____
Parent or Guardian Signature _____Date_____

FOR OFFICE USE ONLY

Piercer: _____ Signa-
ture:_____
Location and description of Piercing: _____
_____

Comments: _____