



**CONSENT TO ADMINISTRATION OF ANESTHESIA  
AND FOR PERFORMANCE OF OPERATIONS  
AND OTHER PROCEDURES**



1. I authorize the following procedure: Circumcision, to be performed by Drs. Laura J. Peterson, M.D. or Bruce W. Hess, D.O. of Ptarmigan Pediatrics, LLC.
2. I consent to additional and different operations or procedures as may be necessary or advisable in the judgment of the doctor in the course of the procedure described above.
3. I consent to the administration of such anesthesia as may be considered necessary or advisable in the judgment of the doctor.
4. Exceptions to surgery or anesthesia, if any, are: No Surgery or Anesthesia.
5. The doctor has explained to me the nature and purpose of the procedure described above, and what the procedure is expected to accomplish, stated in general terms as follows: Elective surgical removal of the foreskin of the penis.
6. The doctor has explained to me the reasonable known risks of the procedure described above, stated in general terms as follows: Infection, bleeding, cosmetic injury to the genitals, and risk of local anesthetic use such as allergic reaction, seizures, or heart rhythm disturbances, or poor cosmetic outcome which may require repeat circumcision.
7. I have been given the opportunity to ask questions regarding the procedure described above and the nature and purpose of the above described procedure, expected results, alternatives, and reasonably known risks. All questions that I have asked have been answered in a satisfactory manner.
8. I consent to the disposal by staff of Ptarmigan Pediatrics of any tissues or parts that may be necessary to remove.

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Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent / Guardian: \_\_\_\_\_

**PHYSICIAN:** I have counseled the parent or legal guardian of the above-named patient regarding the nature of the proposed procedure, attendant risks involved, and expected results as described above.

\_\_\_\_\_  
(Signature of Counseling Physician)

\_\_\_\_\_  
(Date and Time of Signature)

**PARENT / GUARDIAN & WITNESS:** I understand the nature of the proposed procedure, attendant risks involved, and expected results, as described above, and hereby request such procedure to be performed.

\_\_\_\_\_  
(Signature of Parent / Guardian)

\_\_\_\_\_  
(Date and Time of Signature)

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date and Time of Signature)