



**MARYLAND ENT ASSOCIATES**  
**EAR • NOSE • THROAT**  
**FACIAL PLASTIC SURGERY**

**Proudly Part of Privia Health**

## **Informed Consent for Pediatric Tonsillectomy and Adenoidectomy**

### **What is this surgery?**

Tonsillectomy and adenoidectomy (T&A;) is surgery to remove the tonsils (two glands at the back of the throat) and adenoids (tissue behind the nose). This is done through the mouth with no outside cuts.

### **Why is this surgery needed?**

This surgery is often recommended for children who have frequent throat infections, sleep apnea or breathing problems due to enlarged tonsils/adenoids, or difficulty swallowing.

### **Benefits of the surgery**

Fewer throat infections, improved breathing (especially at night), better sleep quality, improved swallowing, better growth and development.

### **Alternatives to surgery**

Continuing medical treatment with antibiotics, observation to see if symptoms improve with time, or doing nothing and living with current symptoms.

### **Risks of the surgery**

Common: throat pain, ear pain (referred), difficulty swallowing, bad breath during healing, voice changes (usually temporary). Less common: bleeding during or after surgery (may require another surgery or blood transfusion). Serious but rare: severe bleeding, airway blockage, dehydration, infection, injury to teeth, lips, or gums. Very rare: severe allergic reaction to anesthesia, damage to surrounding tissues, death.

### **Things you should know**

Recovery usually takes 1–2 weeks. Pain, especially when swallowing, is expected. Drinking plenty of fluids is very important. Bleeding can occur up to 2 weeks after surgery—if this happens, go to the emergency room immediately. Your child may snore for a while after surgery but this usually improves.

### **Consent**

I have read and understood this information (or had it explained to me). I understand the procedure, its benefits, alternatives, and risks. I agree to proceed with Tonsillectomy and Adenoidectomy for my child.

Patient (or Legal Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_