Client Consent Form

Name:	Date:
Address:	Email:
Post Code:	Contact No:

Check if you have ever suffered from the following:

- Eczema
- Sunburn
- Skin Cancer
- Cold-Sores
- Uncontrolled Epilepsy
- Psoriasis
- Conjunctivitis
- Resent Scar Tissue
- Diabetes
- Blood Bone Virus
- Stye
- Moles
- Allergies
- Blood/Circulatory Disorders
- Haemophilia

** Contact lenses must be removed during the process.

** If you have sunbun, peeling or the skin is broken in the treatment area/s, the procedure cannot be done.

* Are you pregnant or breastfeeding ○ Yes ○ No

* Are you prone to flare ups or sensitive skin ○ Yes ○ No

Any Additional Information _____

_____

** I understand that patch test does not guarantee that an allergic reaction will occur.

Patch Test Area :_____Date:_____Result:_____

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information.

I have been informed and understand the contradictions to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable.

_____ _____

Client Signature Technicians Signature

_____

Parent/Guardian Signature