**Tattoo & Skin Consent Form**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently on any medication?** YES/NO

Please list ALL medications taken in the last week:

1. **Please tick any of the following that may apply to you:**

* Do you drink alcohol? If so, how much have you had in the last 24 hours.
* I am on blood thinner medication
* I am diabetic
* I am pregnant
* I take aspirin
* I am breastfeeding
* I have blood clotting problems
* I have heart palpitations
* I have high blood pressure
* I have had hepatitis/HIV
* I have had facial surgery in the last 3 months?
* I currently take antibiotics
* I have allergies
* I wear contact lenses
* I have eye disorders a I have keloid scarring
* I am using lash enhancement serum
* I have had/have cold sores
* I have taken Roaccutane medication in the last 6 months
* I take Retin A medication and/or topical medication

1. **Have you had any of the following treatments in the last 6 months?**

* IPL Facial Rejuvenation Laser resurfacing LED Therapy Solarium a Microdermabrasion
* Chemical Peel
* Muscle relaxant injections or Botox
* Dermal filler injections
* Cosmetic Tattooing and/or removal
* Facial cosmetic/plastic surgery
* Electrolysis / Diathermy Photo Dynamic Therapy (PDT)

1. **Do you use any topical cosmeceutical ingredients in your skin care including any of the following on a regular basis?**

* AHAs (Alpha Hydroxy Acids) including Glycolic and Lactic acids
* BHA (Beta Hydroxy Acid) including Salicylic acid
* Vitamin A (Tretinoin/Retinoic Acid/Retinol/Retinyl Palmitate)
* Vitamin C (Ascorbic Acid)
* Benzoyl Peroxide
* Vitamin A (Retinol)

1. **What is your skin type:** NORMAL / OILY / DRY / COMBINATION
2. **What is your current skin care regime?**
3. **Treatment**

* Microblading tattoo
* Combination brow tattoo
* Ombre/powder brow tattoo
* Lip tattoo
* Eyeliner tattoo
* Non-laser tattoo removal
* Microdermabrasion
* Chemical peel
* Skin needling
* Dermaplaning

**I UNDERSTAND:**

I understand that this treatment is for cosmetic purposes only. That no guarantee has been made to me regarding the results as I understand that every skin responds differently and have not received any guarantees on the outcome of the process.

I am responsible for all the "at home care" using only the aftercare product in my at home care advice if not I may have risk of infection or fading of pigments if not carried out fully.

I consent to before and after photographs of this procedure which is at the therapist's discretion.

I cannot donate blood within 6 months from today (tattoo & needling).

I consent to the use of topical anaesthetics containing benzocaine, lidocaine, tetracaine & epinephrine and understand that the use of numbing cream may have an adverse reaction.

I am aware that I may require a follow up visit in 6 weeks' time to achieve the final result or adjustment for cosmetic tattoo or removal.

I have been given aftercare instructions and fully comprehend every instruction and will follow to the best of my ability.

I understand there will be no refunds given if the desired result is not achieved. I am over 18 years of age.

I understand I may experience mild discomfort during the treatment, possible bleeding during the treatment, possible bruising or inflammation post treatment, possible skin grazing over concentrated areas post treatment, mild redness and swelling.

Client signature: Date: