ELECTROLYSIS TREATMENT RELEASE FORM Area(s) to be treated ____________________

Name ____________________ DOB ____________________

Please check all past and current methods of hair removal used.

- [ ] Sugaring
- [ ] Laser
- [ ] Tweezers
- [ ] Wax
- [ ] Shaving
- [ ] None
- [ ] Bleach
- [ ] Other ____________

When was the last time you removed the hair on the area to be treated? ____________________

Please list anything notable about your skin's reaction to hair removal.

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Please list any skin or hair abnormalities, sensitivities, or general concerns.

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HAIR

Texture

- [ ] Curly
- [ ] Wavy
- [ ] Coiled
- [ ] Frizzy
- [ ] Straight

Density

- [ ] Fine
- [ ] Normal
- [ ] Thick

SKIN

Tone

- [ ] Dark
- [ ] Medium
- [ ] Light

Thickness

- [ ] Thin
- [ ] Average
- [ ] Thick

Type

- [ ] Dry
- [ ] Dehydrated
- [ ] Normal
- [ ] Oily
- [ ] Combination
- [ ] Acne

MEDICATIONS

- [ ] Cortisone
- [ ] Anticoagulants
- [ ] Hormonal treatments
- [ ] None
- [ ] Other ____________

ALLERGIES

- [ ] Latex
- [ ] Metal
- [ ] Topical cosmetics
- [ ] None
- [ ] Other ____________

MEDICAL CONDITIONS

- [ ] Congenital hypertrichosis
- [ ] Acquired hypertrichosis
- [ ] Metallic implants
- [ ] Circulatory deficiency
- [ ] Sensory deficiency
- [ ] IUD
- [ ] Skin diseases
- [ ] Pace maker
- [ ] Pregnancy
- [ ] Epilepsy
- [ ] Hepatitis
- [ ] HIV
- [ ] Hemophilia
- [ ] Keloids
- [ ] Anxiety
- [ ] Severe insulin dependent diabetes
- [ ] Anxiety
- [ ] None
- [ ] Other ____________

If you have previously received electrolysis treatments, please provide the following:

Business/electrologist name and location

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Date of last treatment ____________

# of treatments ____________

Probe size ____________

Method(s) used:

- [ ] Thermolysis
- [ ] Electrolysis
- [ ] Blend

OFFICE NOTES

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CLIENT CONSENT TO ELECTROLYSIS TREATMENT

My signature below and my initials at each paragraph acknowledge that I have read the following statements and agree to receive electrolysis treatments. I verify that I have answered these questions to the best of my knowledge, and I consent to receive treatment at Southern Sugaring & Spa.

I, ________________________________, authorize Southern Sugaring and its employees to perform electrolysis treatments on myself.

Please read each of the following statements and initial to acknowledge your understanding and agreement.

_____ The nature and purpose of the treatment have been explained to me, and any questions I have regarding this procedure have been explained to my satisfaction.

_____ I do not have any of the conditions (Pacemaker, metallic implant, diabetes, pregnancy, medical condition delaying healing process, blood thinning drugs, embolism or phlebitis) contraindicated with electrolysis treatments.

_____ I understand that with any treatment, certain risks are involved and that complications or side effects from known or unknown causes can occur. I freely assume these risks.

_____ Side effects might include mild redness, extreme redness, local swelling and stinging. Most side effects are temporary and generally subside within one week to 21 days.

_____ I have been advised not to touch or rub treated areas, not to pick scabs, to let them fall off by themselves. I understand that I must keep the treated area clean and use hydrating and healing products, avoid sun exposure for one week and use total sun block on treated area until complete healing.

_____ I have received a copy of Post-Care instructions.

_____ During cold sores, inflammatory acne or other eruptions, it is necessary to discontinue the treatment to avoid spreading the eruption. The procedure should be deferred until the skin is perfectly healed.

_____ I am over 18 years old.

_____ I have read the above explanations and treatment recommendations and understand the potential risks and benefits of treatments.

______________________________________ ______________________

Signature Date