

Patch Test *Consent/Waiver Form*



Client details

Full Name _____

Contact Number _____

Medical history

Do you have any existing allergies? ☐ Yes ☐ No

Do you have any medical conditions ☐ Yes ☐ No

Have you previously experienced any reactions to dye/tint/treatment/product? ☐ Yes ☐ No

Do you have any eye sensitivities? ☐ Yes ☐ No

Are you currently wearing contact lenses? ☐ Yes ☐ No

If you answered **yes** to any of these questions, please disclose here:

Consent

While allergies to treatments are unusual, it is always possible to have a reaction in regards to any new treatment we undertake. Please read the following statements carefully.

Please tick each statement to show your understanding and agreement:

☐ I confirm that I have disclosed all relevant information to my therapist

☐ I confirm I have had all potential side effects/reactions explained to me in regards to this treatment

Please tick one of the following statements that is applicable to you:

☐ I am having my patch test today and I understand that even though only a small area is treated there is a possibility there may be a reaction within this area, and I am choosing to go ahead with this treatment taking all benefits and potential side effects into consideration

☐ I am consenting to having my treatment today without having a patch test. I understand why they are recommended but I have decided that I knowingly and voluntarily waive this skin patch test for today. I acknowledge that a patch test is available at any time as per my request

Client Signature _____

Client Name _____ Date _____

Therapist Signature _____