PERMANENT MAKE UP CONSENT FORM

Your Full Name (required)_____ _____
Your Email (required)_____ _____Today's Date (required)_____
Your Address_____
Date of Birth_____Occupation_____
Employer_____Telephone (work)_____
Mobile Number_____Referred by_____
Procedure Requested:
Permanent Eyeliner Top ☐ Permanent Eyeliner Bottom ☐ Permanent Eyebrows ☐
Fees for the intended procedure/s_____
Have you previously had the requested procedure/s done?_____ _____
If Yes to the above question, who did the procedure?_____ _____
When was the procedure done?_____ _____
What products were used?_____ _____
Were you satisfied? _____
If not: Why? _____
Do you anesthetize easily with dental procedures?_____ _____

ALLERGIES

List any drug, make-up or skin allergy that you have. This includes soaps, cleansing creams, earrings (other than gold), Novocain (local anaesthetic) or any derivative of caine, latex, powders, menthol, petrolium, sulfa & zinc:

_____
Have you recently undergone a skin peel? _____
Are you undergoing any laser treatment? _____
Are you prone to any of the following:
Keloid Scaring (severe elevated scaring) ☐ Hyper Pigmentation (darkening skin from injury) ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions: (Please tick where appropriate)

Abnormal Heart Condition		Low Blood Pressure (Hypotension)	
Fainting/Dizzy Spells		Blepharoplasty (Surgery to eyelid)	
Cold Sores/Herpes Simplex		Diabetes	
Glaucoma (vision loss due to high blood pressure)		Tumours/Growths/Cysts	
Cancer/Chemotherapy/Radiation		High Blood Pressure (Hypertension)	
Corneal Abrasion(Chemical Burn)		Skin Disorder	
Eye Surgery or Eye Injury		Visual Disturbance	
Circulatory Problems		Cataracts	
Haemophilia		Dry Eyes	
Epilepsy		Hepatitis	
Auto-Immune Disease (eg HIV)		Currently Pregnant	
Wear Contact Lenses		Smoker	

Are you or have you been in the care of a physician in the past two years?_____ _____
If yes, please specify what you are/were being treated for?_____ _____
List all medications and supplements you are currently taking:(including Retina A, Glycol Acid and Ro-Accutane)_____
_____
_____
Are you using any eyedrops or other ocular medication?_____ _____
Are you taking Ibuprofen and/or Asprin?_____ _____
When was your last eye exam?_____ _____
Please confirm eye physician's name & contact number_____

I, hereby confirm that I have been informed of the procedure to be performed thus allowing me to make an informed decision whether to undergo the procedure or not.(sign)_____ _____

APPLICATION FOR PERMANENT COSMETICS

Please tick to confirm your acknowledgement of each point below:

☐ I am aware that the recommended procedure to be used is Micro Pigment Implantation. This is a form of tattooing used for the purpose of permanent make-up and the camouflaging of skin imperfections.

☐ I have been informed that the markings are permanent and that there is a risk of infection after the procedure. Adequate aftercare will be given by your specialist.

☐ I voluntarily request that my intradermal cosmetic technician do as she may deem necessary to perform on my body the procedure.

PLEASE TICK WHERE APPLICABLE:

I hereby authorise my technician to take photos of the treated area before and after the treatment
For record purpose only ☐ For use in advertising ☐ No photos please ☐

PLEASE CONFIRM THE FOLLOWING:

I have informed my cosmetic technician that I am in good health and not under the care of a physician for any of the relevant conditions as previously listed (sign)____ _____

GENERAL PROCEDURE INFORMATION FOR:

Please read the following and acknowledge the information by signing below

Permanent Cosmetics

• I understand that the description of the procedure is not intended to scare or alarm me. It is simply an effort to fully inform me so I may give or withhold my consent for the procedure/s.
• I understand that no warranty or guarantees have been made to me regarding the results.
• I understand that there may be a possibility of hyper pigmentation/scarring resulting from the procedure/s, (please note if you are prone to hyper pigmentation/keloid scars from previous scars or injuries).
• I have been informed of the risks and hazards related to the treatment scheduled for me.
• I have been informed that the procedure/s may involve pain and discomfort.
• I have been informed that a follow up procedure may be required and that the colour of the pigment used may fade.
• I have been informed that there is a chance that I may experience a corneal abrasion from the eyeliner procedure.
• I understand that I may develop blisters (fever blisters, if prone) & that there may be swelling & pain following the procedure.
• I have been informed that I could have an allergic reaction to the pigment / products & that my body may reject the pigment in some cases.
• I acknowledge that the manufacturer of the pigment applied required spot testing & specifically disclaims any responsibility for any adverse reactions to the applied pigment. I understand that spot testing may indemnify individuals who develop immediate reaction to pigment, however, spot testing does not identify individuals who may have delayed allergic reaction to the pigment applied.

Sign_____

Please select which option you would like to proceed with:
Please note that if you choose to have the allergy test done there is a 72hour waiting period for the results.
I agree to WAIVER the allergy test ☐ I want the allergy test done ☐
I waive a spot test prior to application & I agree to release Premier Permanent Franchise, Franchise Manufactures from any & all liability related to allergic reaction to applied pigment.
Accept ☐ Deny ☐

Confirm the following by signing below:

• I have been given an opportunity to ask any questions about the procedure/s to be used and the risks and hazards involved.
• I believe that I have sufficient information to give informed consent.
• I have been informed of the risks associated with my particular medical condition (as stated above) but would still like the procedure to be done & in the event of any further problems I may experience & decide to sue, I undertake to pay all costs.
• I understand that if I have any infection, allergic reaction or adverse reaction to the procedure, I must notify my technician.
• I confirm that this form has been fully explained to me & that I have read it or had it read to me, and I understand the content.
• I understand that should I have laser treatment, my permanent make-up must be covered by toothpaste or zinc oxide to prevent fading.
• I confirm that all information provided by myself is true and correct.

Full Name & Surname_____

Sign_____ ***Please note that if you do not sign your appointment will not proceed.