



RENU SKIN CENTER

PARAMEDICAL TATTOOING – SCAR CAMOUFLAGE – SMP

A valid government ID must be presented at the time of procedure

INFORMED CONSENT, MEDICAL HISTORY & RELEASE FORM

Client Name: _____

Address/City/State/Zip: _____

Email: _____

Age: _____ Phone #: _____ Date: _____

What procedure(s) are you having done today?

How did you hear about ReNu Skin Center?

RISKS AND HAZARDS

You have the right to be informed so that you may make the decision whether or not to undergo the procedure(s) after knowing the risks and hazards involved. Please read the statements below and type your initials before each one to indicate you understand them completely. It is your responsibility to inform the technician of all possible concerns before they begin your procedure.

_____ I understand permanent makeup is a form of tattoo that requires implantation of pigment into my skin using a needle.

_____ I understand there may be risks and hazards related to the performance of this procedure, including but not limited to: allergic reaction to the pigment and/or other products that will be used, dizziness, bleeding, bruising, swelling, scarring and infection.

_____ I understand that it is my responsibility to advise my technician of **any** concerns I may have before they begin the procedure, even though I may not have written them down on this form.

_____ I understand there is a **no refund** policy and no warranty or guarantee has been made to me as a result of this procedure. Although my technician will do their best to make sure I am happy with the result, the final result cannot be guaranteed.

_____ I understand that tattoo inks/dyes/pigments have not been approved by the Federal Food and Drug Administration (FDA), and that the health consequences of using these products are unknown.

_____ I understand some permanent makeup pigment can only be removed with a surgical procedure, and any effective removal may leave permanent scarring or disfigurement. Also, under rare circumstances,

Clients Initials: _____

misplacement of the permanent makeup pigment can occur, requiring excision of the misplaced permanent makeup pigment. In extremely rare cases, there may be permanent loss of eyelashes.

_____ I will receive aftercare instructions and will ask questions if I do not understand them. Further, I agree to follow all instructions concerning care of my procedure.

_____ I have been informed that I am required to come back for a touch up appointment within 4 to 6 weeks after the initial procedure.

_____ I understand that I will pay a fee for the annual or subsequent touch ups.

_____ I consent to have photos and/or videos of the procedure area to be taken and possibly posted online/ social media.

CONFIDENTIAL MEDICAL HISTORY

Are you currently under medical care?	___	Yes	___	No
Have you had Botox/Dysport or any fillers in the last two weeks?	___	Yes	___	No
Are you pregnant or trying?	___	Yes	___	No
Do you have any allergies?	___	Yes	___	No If yes:_____
Prone to cold sores?	___	Yes	___	No
Are you a hemophiliac?	___	Yes	___	No
Do you have diabetes?	___	Yes	___	No
Do you have any heart conditions?	___	Yes	___	No
Do you have high or low blood pressure?	___	Yes	___	No
Do you have Hepatitis A, B or C?	___	Yes	___	No
Are you HIV positive?	___	Yes	___	No
Do you wear contact lens?	___	Yes	___	No
Do you have cataracts?	___	Yes	___	No
Are you photosensitive?	___	Yes	___	No
Do you have epilepsy?	___	Yes	___	No
Do you have any contagious diseases?	___	Yes	___	No If yes:_____
Do you have any skin conditions?	___	Yes	___	No If yes:_____
Do you have or have you recovered from cancer?	___	Yes	___	No
Have you been under the influence of drugs or alcohol in past 24 hours?	___	Yes	___	No
Have you had any cosmetic injections in the last 3 months?	___	Yes	___	No If yes:_____
Currently taking any pain medication over-the-counter or prescribed?	___	Yes	___	No List:_____
Have you had any caffeine in the last 24 hours?	___	Yes	___	No
Are you currently taking immunosuppressants?	___	Yes	___	No
Are you currently taking Acutane?	___	Yes	___	No

Clients Initials: _____



Are you currently using Retin-A or rapid exfoliators? ___ Yes ___ No
 Do you have asthma? ___ Yes ___ No
 Do you take fish oil or blood thinners? ___ Yes ___ No

SKIN TYPE / FACIAL ANALYSIS

Describe your skin type: ___ Oily ___ Dry ___ Combo
 Describe your skin thickness: ___ Thin ___ Normal/Medium ___ Thick
 Do you have: ___ Acne ___ Rosacea ___ Hyperpigmentation

Are you prone or do you currently have:

 Scar Tissue? ___ Yes ___ No
 Keloid? ___ Yes ___ No
 Concave Scarring? ___ Yes ___ No
 Prior Permanent Cosmetics? ___ Yes ___ No

VERY IMPORTANT QUESTION:

If you get a cut, scratch, scar, mosquito bite, etc. does it turn Darker when it starts to heal? Yes No

Is there any other information you feel you should provide to your Technician? If yes, write here and ask to discuss before the procedure begins: _____

I, _____ certify that this Informed Consent, Medical History and Release Agreement was completed by me and that all entries in it and information are true and complete to the best of my knowledge. I also certify that I have been fully informed of the risks of tattooing/permanent makeup application, including but not limited to: infection, scarring, difficulties in detecting melanoma, and allergic reactions to permanent makeup/tattoo pigment, latex gloves, and other products used. Having been informed of the potential risks associated with getting the permanent makeup/tattoo, I still wish to proceed with application and I assume any and all risks that may arise from the procedure.

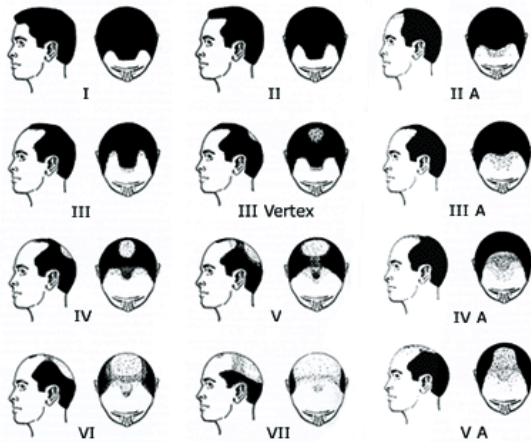
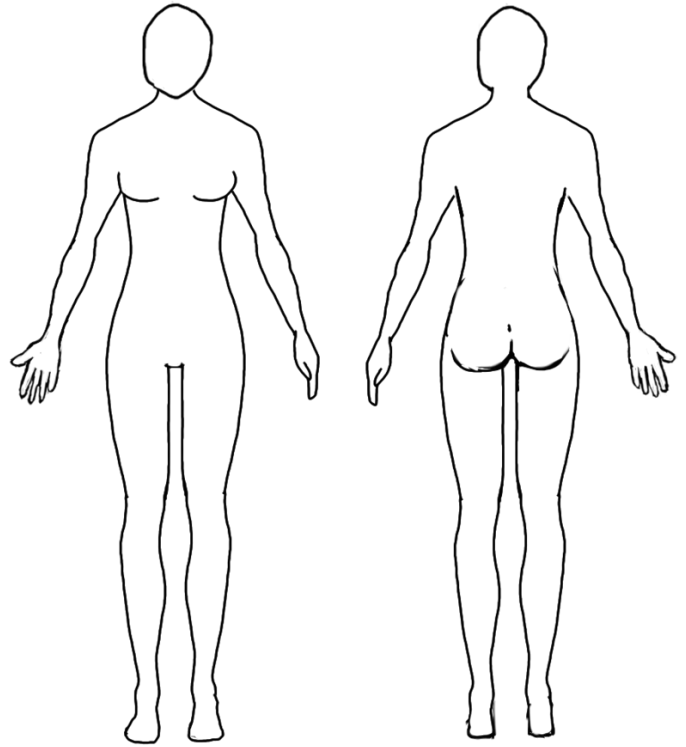
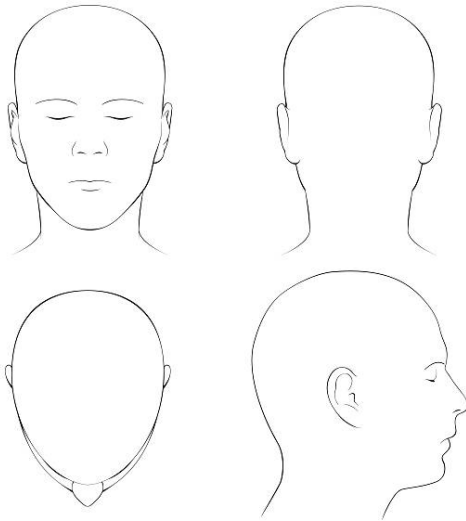
I also certify that I take full responsibility and waive any claims against Elite Permanent Makeup and/or my Technician to the fullest extent permitted by law from all liability whatsoever, for any and all claims or causes of action that I, my estate, heirs, executors or assigns may have for personal injury or otherwise, including any direct and/or consequential damages, which result or arise from the application/implantation of permanent makeup pigment for eyeliner, eyebrows, lips, repigmentation, camouflage or otherwise, whether caused by the negligence or fault of either the Technician, ReNu Skin Center or otherwise.

The medical history information I have provided above is complete and true to the best of my knowledge.

Client's Signature _____ Date _____



AREA OF WORK FOR PRECEDURE



The Fitzpatrick Scale

TYPE I Light, pale white <small>Always burns, never tans</small>	TYPE II White, fair <small>Usually burns, tans with difficulty</small>	TYPE III Medium, white to olive <small>Sometimes mild burn, gradually tans to olive</small>	TYPE IV Olive, moderate brown <small>Rarely burns, tans with ease to a moderate brown</small>	TYPE V Brown, dark brown <small>Very rarely burns, tans very easily</small>	TYPE VI Black, very dark brown to black <small>Never burns, tans very easily, deeply pigmented</small>

For Technician Use Only:

Technician name (print name): _____ Signature: _____ Date: _____

Client has initialed / signed all areas of this document and I have answered all questions. _____ (initials)

Machine used: _____

Needle type(s), size(s) and lot number(s): _____

Pigment brand(s), color(s), lot numbers and/or expiration date(s): _____

Other notes: _____

Client's Authorization Signature: _____

