

SEMI PERMANENT MAKE-UP

by Bella Terry

lip colouring consent form

section one || purpose of this form

This form is designed to give information needed to make an informed choice of whether or not to undergo a Lip Colouring semi-permanent make up application. It is the responsibility of the client to read all four sections carefully and sign where needed.

If you have questions please do not hesitate to ask – get in touch at spmubybella@gmail.com

section two || photography consent form

We would like your permission to use these photos for advertising. For example, in portfolios, website, social media online and in print ads, etc. Your consent is necessary regarding this.

Please mark and indicate with your signature if you would like your photos used or not used in advertising.

Yes

No

signed Click here to enter text.

date Click here to enter text.

section three || client medical information

full name Click here to enter text.

date of birth Click here to enter text.

today's date Click here to enter text.

patch test date Click here to enter text.

email Click here to enter text.

mobile Click here to enter text.

emergency contact name Click here to enter text.

emergency contact number Click here to enter text.

please indicate if you currently have or have previously had any of the following;

Heart condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Haemophiliac	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bruise or bleed easily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Alopecia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Artificial heart valves	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blurred vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chapped Lips	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Circulatory problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cold sores/Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye infection	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting spells/dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pregnant/Nursing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Healing problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hypertrophic scars	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Keloid scars

Yes No

please continue to indicate if you currently have or have previously had any of the following and add notes where necessary;

Taking blood thinners;

(such as Aspirin, Ibuprofen, Coumadin etc)

Yes No

Click here to enter text.

Have you had cosmetic filler in the last 3 months?

Yes No

Allergic reaction to any medications, metals etc;

Yes No

Click here to enter text.

Any diseases or disorders not already listed;

Click here to enter text.

Do you use skin care products containing Retin-A, glycolic acid or alpha hydroxyl?

Yes No

Please list medication or vitamins you're currently taking;

Click here to enter text.

Please note any additional requests, information, allergies, health issues or concerns that will be useful to your technician;

Click here to enter text.

I agree that all the above information is true and accurate to the best of my knowledge.

signed

Click here to enter text.

date

Click here to enter text.

section four || statement of consent and procedure permit

Please check the box once read and understood

If any unforeseen condition arises in the course of this procedure(s), calling in her judgement in addition to, or different from the now contemplated, I further request and authorise Bella Terry to do whatever she deems advisable and necessary in these circumstances.

I fully understand, as with all such procedures that this is not a science but rather an art. Depending on the procedure(s) selected, I accept responsibility for determining the colour, shape and position of the lip colouring as agreed during the course of my consultation.

It is understood that a sensitivity (patch) test is available to me and it has been recommended to me by my technician prior to procedure for pigments and topical anaesthetics. The purpose of the test is to detect allergic or other reactions. I understand that if I waiver the test that it is at my own risk if any allergy or react occurs.

Please indicate your decision on the patch test: Waive or Take

I fully understand and accept that non-toxic pigments are used during the procedure(s) and that the cosmetic enhancement achieve may fade in between time scales advised to me. Even though the colour has faded the pigment will stay in the skin indefinitely.

I have been informed that the highest standard hygiene is met, and that sterile disposable needles and pigment containers are used for each individual client, procedure and visit.

I understand and accept that each procedure is a process requiring multiple applications of pigment to achieve desirable results and that 100% success cannot be guaranteed. I understand that this is why I'm advised to return for retouch procedures.

I have been quoted and agreed to the cost of today's appointment and any further arranged retouch appointments.

I understand the result of the procedure is determined by the following;

- Medication
- Skin characteristics
- Natural skin undertones
- Personal pH balance of skin (which changes from visit to visit)
- Alcohol intake and smoking
- Post-procedure care treatment

I understand that upon completion of the procedure there may be swelling and redness of the skin, which will subside in between 1 – 4 days. In some cases bruising can occur. Clients may resume normal activities immediately following the procedure, however, using cosmetics, excessive perspiration and exposure to the sun on the affected area should be limited.

I have been advised that the true colour will be seen one month after each procedure, and that the pigment may vary in colour according to skin tones, skin type, age and skin conditions. I understand that some skins except pigment more readily than others and no guarantee to an exact affect or colour can be given.

I am aware that the lip procedure may stimulate any dormant virus such as herpes (cold sores).

To my knowledge I do not have any physical, mental, or medical impairment or disability that might affect my well-being as a direct or indirect result of my decision to have the procedure done at this time.

I certify that I have read or have had read to me the contents of this form and given all relevant personal health information to the best of my knowledge. I understand the risks and alternatives involved in this procedure(s) and I have had the opportunity to ask questions and all of my questions have been answered. I acknowledge that I have reviewed and approved the material given to me and I authorise Bella Terry at SMPU by Bella, as my technician to perform on my body the Lip Colouring procedure desired today.

signed Click here to enter text.

date Click here to enter text.
