Laser Consent Form

- I authorize _________________ to perform Kiran's treatments on me in an effort to improve Hair Reduction or other: ________________________
- I understand that there is a possibility of side effects or serious complications during all laser services. This includes permanent discoloration and scarring.
- I understand the below list of short-term effects:
  - **Discomfort** – during the procedure and shortly after, there may an "itching" sensation which may vary with hair density and the general area of sensitivity. A mild "sun-burn" sensation may follow for an hour but will disappear quickly.
  - **Perifollicular erythema/edema** – severity and duration of a "rash-like" raised/red area may depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams
  - **Micro-crusting** over some areas with very dense and coarse hair – may take 5 to 10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring
  - **Bruising** may rarely occur and can last several days
- I understand that sun exposure or tanning of any sort is not recommended and may increase the chance for complications
- Pre and post-care instructions have been discussed and acknowledged
- I understand that results may vary with each individual and that a series of treatments must be conducted at the prescribed treatment intervals
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my patient record

Print Name	Treatment Provider
______________________	______________________
Date	Date
______________________	______________________
Signature	Signature
______________________	______________________

Medical History

Skin type of the area to be treated: I ◻ II ◻ III ◻ IV ◻ V ◻ VI ◻		
Natural or artificial sun exposure in the past 3-4 weeks pre and post treatment	NO	YES
Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc…) or aromatherapy (essential oils)	NO	YES
Diseases which may be stimulated by light at 805 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO	YES
Pregnant or possibility of pregnancy, postpartum or nursing	NO	YES
Inflammatory skin conditions (dermatitis active acne, etc…)	NO	YES
Presence or history of active cold sores or herpes simplex virus	NO	YES
HIV	NO	YES
Active cancer (currently on chemotherapy or radiation)	NO	YES
Previous skin cancer?	NO	YES
Medical history of keloids	NO	YES
History of livedo reticularis	NO	YES
	NO	YES
Intake of Accutane within the past 6 months	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES
Any known allergy?	NO	YES
Any tattoo and/or dysplastic nevi on requested treatment area that should be protected?	NO	YES
Intake of aspirin or anti-coagulants?	NO	YES
Easy bruising?	NO	YES
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES
Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…) Within the past 6 weeks?	NO NO	YES YES
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc…)	NO	YES
List of additional current medication taken		

Print Name

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Date

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Signature

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Treatment Provider

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Date

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Signature

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