Schenden's
medical day spa

CONSENT FOR NAIL TREATMENTS

Client Name: _____ Age** _____ Date of birth: Mm/dd/yy

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Home ❍ Cell ❍ Work ❍ Other ❍ _____ Home ❍ Cell ❍ Work ❍ Other ❍ Email: _____

How did you hear about us? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

***IF under 18: Information of responsible adult*

Name: _____ *Relationship To Client:* _____

Contact Phone: _____ *Signature/authorization* _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

☐ Yes ☐ No Is this your first nail service?

Date of Last manicure: _____ Date of last Pedicure: _____

Allergic to: ○ Latex ○ Herbs ○ Seasonal ○ Foods ○ Metal(s) ○ Citrus

List any Medication allergies: _____ Other: _____

☐ Yes ☐ No Have you taken any blood thinning products within the past 3 months?

☐ Yes ☐ No Are you diabetic?

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Do you have any infectious disease(s)?

Other conditions please explain: _____

FOOT CONDITIONS **PLEASE NOTE: MANY FOOT CONDITIONS ARE STILL CONTAGIOUS DURING TREATMENT.**

There are some highly contagious foot conditions. As a consideration to the other clients and Nail Techs we need to know if you have had any of the following within the last year.

☐ Yes ☐ No **Planters Wart:** Are very painful and tender. The core grows into the foot. Often they appear with a black dot on the surface of the skin. They are usually rough, bumpy and spongy. Some may be thick and scaly.

☐ Yes ☐ No **Verrucas Wart:** Appear as pale, slightly raised lesions on the soles of your feet

☐ Yes ☐ No **Athlete's Foot:** Persistent itching in the affected area, white and moist skin.

☐ Yes ☐ No **Nail Fungus:** Often the first sign of nail fungus is a change in color of the toe nail. The nail bed will often change to a creamy white, yellow or even green. The nail will also raise and get very thick.

☐ Yes ☐ No **Ulcer:** An open sore or breaks in the skin, often an indicator of circulation problems and/or diabetes.

☐ Yes ☐ No If you have any other foot related illnesses that we should know about?

I understand that services offered are not a substitute for medical care, and any information provided by the therapist(s) is confidential and for educational purposes only. I do not need a doctor's release for any services provided.

_____ _____

*Client Signature*** *Date* *Technician Signature* *Date*

*****If client is under 18- Signature of Responsible Adult Required*