BEAUTY BY BOLE BOUTIQUE & CLINIC
CLIENT CONSENT & DISCLAIMER FORM

Client Name: _____ Date: _____

Date of Birth: _____ Practitioner: _____

1. TREATMENT ADMINISTERED

■ Facial Aesthetic Injection ■ IV Vitamin Drip ■ Vitamin/Wellness Booster Injection ■ Compression Boot Therapy
■ Pelvic Floor Chair Therapy ■ Immunisation ■ Advice / Consultation

2. HEALTH DECLARATION

I confirm that I have provided accurate information about my health, medical history, allergies, medications and any relevant conditions. I have
informed the practitioner of any pregnancy/breastfeeding, allergies, medical conditions or previous reactions that may affect my treatment.
I understand that the practitioner may postpone or decline treatment if it is considered unsuitable or unsafe.
☐ A. Medical History ☐ B. Allergies ☐ C. Medications ☐ D. Any Additional Relevant Information

3. CONSENT & RISKS

• I understand the nature and purpose of my chosen treatment and have had the opportunity to ask questions.
• I understand that treatments may have risks and side effects, which may include discomfort, redness, swelling, bruising, dizziness, irritation, infection, allergic reaction or other treatment-specific complications.
• For IV therapy and injections, I understand that additional risks may include bleeding, vein irritation, infiltration/extravasation and, rarely, a serious allergic or other medical reaction.
• For compression boots and pelvic floor chair therapy, I understand that temporary discomfort, pressure, muscle fatigue or other treatment-specific effects may occur.
• I understand that results vary between individuals and no specific outcome is guaranteed.

4. CLIENT AGREEMENT

• I understand that these treatments are not a substitute for appropriate medical care and that I should continue any prescribed treatment unless advised otherwise by an appropriate healthcare professional.
• I confirm that the treatment, potential benefits, risks and alternatives have been explained to me and that I am giving my voluntary and informed consent.
• I understand that I may withdraw my consent before or during treatment, subject to the safety of stopping the treatment.
• I acknowledge that this consent form does not remove the clinic's legal or professional responsibility to provide safe and appropriate care.

5. ADDITIONAL IV DRIP DISCLAIMER & CONSENT

5.1 IV DRIP TREATMENT LIMIT

I understand that I should receive no more than 9 IV vitamin drips within any 6-month period, unless otherwise clinically assessed and authorised by an appropriately qualified healthcare professional.
Should I wish to exceed this limit, I understand that I will be required to complete and sign an Additional IV Drip Disclaimer Form before receiving any further IV treatment.
I understand that each treatment is subject to a health assessment and suitability check, and that treatment may be declined or postponed where it is considered unsuitable or unsafe.

5.2 ADDITIONAL IV DRIPS

I understand that if I wish to exceed the recommended maximum of 9 IV drips within 6 months, I will be required to complete and sign an Additional IV Drip Disclaimer Form before any further treatment is provided.
I acknowledge that exceeding the recommended number of treatments is my choice and does not guarantee any additional benefit. I understand that the clinic may decline to provide further treatment where it is considered clinically inappropriate or unsafe.

5.3 CLIENT DECLARATION

I confirm that I have provided accurate and complete information regarding my health, medications, allergies and previous treatments.
I understand that withholding relevant information may increase the risk of complications.
I voluntarily consent to treatment and accept responsibility for proceeding beyond the recommended treatment frequency.
Client Signature: _____ Date: _____

6. TREATMENT RECORD

Treatment provided: _____ Product/medicine (if applicable): _____
Dose/volume (if applicable): _____ Batch/Lot No.: _____ Expiry: _____
Adverse reaction: ■ No ■ Yes Notes: _____
Client Signature: _____ Date: _____
Practitioner Signature: _____ Date: _____

Beauty By Bole Boutique & Clinic • Aesthetic & Wellness Treatments • Nurse-Led Clinical Care • Safe • Professional • Confidential

If you have any questions or concerns, please speak to your practitioner.