Informed Consent & Release for Latisse

Name: _____
First Middle Last

Address: _____
Street City State Zip

Phone: (h)_____ (w)_____ (c)_____

DOB: _____/_____/_____ How did you hear about us:_____

Email: _____

Do you have any known allergies or skin sensitivities?

Please list chronic medical conditions:

What medications are you currently taking? (including over the counter vitamins, herbs, and supplements)

Initial each statement if you understand and agree.

_____ I understand that I cannot use Latisse solution if I am allergic to one of its ingredients.

_____ I understand that Latisse solution should not be used while nursing or pregnant.

_____ I understand that the most common side effects after using Latisse solution were itching sensation in the eyes and or eye redness. This was reported in approximately 4% of patients. Latisse solution may also cause other less common side effects which typically occur on the skin close to where it has been applied on the eyes. (Skin hyperpigmentation, eye irritation, dryness of the eyes, and redness of the lids).

_____ I understand the need to inform you if I have a history of eye pressure problems and that I should inform anyone conducting an eye pressure screening that I am using Latisse solution.

_____ I understand that I should remove my contacts prior to using Latisse solution, and should not sleep with my contacts in while using Latisse solution.

_____ I understand that I should use Latisse solution ONCE nightly on the upper eyelid margin at the base of the eyelash going from the inner part of the lash line to the outer. I SHOULD NOT APPLY TO THE LOWER LID.

_____ I understand that Latisse solution is 0.03% bimatoprost ophthalmic solution. It is a prescription treatment for hypotrichosis used to grow eyelashes, make them longer, thicker and darker.

This consent form is valid for 24 months from the date signed.

Client Signature Date

Spa 360 Staff Signature Date