



LOTUS PROFESSIONAL COLLEGE

Esthetics Confidential Volunteer Health History Form

Date: ____/____/____

Name: _____ Date of Birth: ____/____/____ If under 18 requires
parent/guardian signature

Address: _____ E-mail: _____

Cell Phone: _____ Home Phone: _____ Business Phone: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? O No O Yes, explain: _____

2) Any recent surgery, including plastic surgery? O No O Yes, explain: _____

3) Any skin cancer? O No O Yes, explain: _____

4) Have you had any piercings, tattoos, permanent cosmetics? O No O Yes, If Yes, where on your person?

5) Do you smoke? O No O Yes

List any medications you take regularly: _____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly: _____

6) Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

Cancer	<input type="checkbox"/>	Headaches (Chronic)	<input type="checkbox"/>
Hormone imbalance	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Systemic disease	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	frequent cold sores	<input type="checkbox"/>
Spinal injury	<input type="checkbox"/>	Immune disorders	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Metal bone pins or plates	<input type="checkbox"/>

Heart problem	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Psychological treatment	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Keloid scarring	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>
Skin disease/skin lesions	<input type="checkbox"/>	Fever Blister	<input type="checkbox"/>
Any active infection	<input type="checkbox"/>		
Phlebitis, blood clots, poor circulation, varicose veins		Blood clotting abnormalities	<input type="checkbox"/>

7) Has your physician discussed concerns about raising your body temperature? O No O Yes

Explain:

8) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? O No O Yes

9) Have you used any of these products in the last 3 months? O No O Yes

10) Have you used an acne medication? O No O Yes, when? _____ Which drug? _____

11) Do you form thick or raised scars from cuts or burns? O No O Yes

12) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? O No O Yes, describe: _____

13) Do you wear contact lenses? O No O Yes

14) Have you been exposed to the sun or used a tanning bed in the last 48 hours? O No O Yes

15) How frequently are you exposed to the sun or use a tanning bed?

_____ Infrequently _____ Frequently _____ Regularly

16) Do you have any metal implants or wear a pacemaker? O No O Yes

17) Have you ever had an adverse reaction after using any skin care product? (Circle all that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

18) Have you ever had an allergic reaction to any of the following? (Circle all that apply)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: _____

If yes, please explain:

Female Volunteers Only (questions 19-22):

19) Are you taking oral contraceptives? O No O Yes

20) Are you pregnant or trying to become pregnant? O No O Yes

21) Are you lactating? O No O Yes

22) Any menopause problems? O No O Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

* * * * *

I, _____, agree to be a client volunteer and understand that this practice esthetics session is ***free of charge***. I understand there will be a nominal school administration fee. A 24 hour notice is required if I need to cancel or reschedule my appointment. If I do not provide the required notice, I am responsible to pay 50% of the administrative fee prior to scheduling any future appointments. This practice session is intended to be a learning experience for the student. I agree not to hold the student, responsible for anything that occurs as a result of this esthetics session. It is my responsibility to let the student know if the esthetics techniques being used during the session cause discomfort in any way.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the student / teacher of my current medical or health conditions and to update this history. I understand that receiving esthetic treatments could cause bleeding, bruising, and/or scarring. The treatments I receive here are voluntary and I release the Lotus Professional College, faculty and students from liability and assume full responsibility thereof.

If volunteer is a minor under 16 years of age, parent or guardian must be present for consultation and treatment.

If volunteer is a minor between 16 and 18 years of age, parent or guardian must be present for consultation and is encouraged to stay during the treatment.

Volunteer Signature: _____ Date: ____/____/____

*Parent/Legal Guardian: _____ Date: ____/____/____

**Required if client under 18 years of age*

Volunteer Name: _____

I hereby consent to and authorize _____ to perform the following procedure:
Student Name

Treatment/Procedure: _____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards.

Date: ____/____/____ Initial _____

I hereby consent to and authorize _____ to perform the following procedure:
Student Name

Treatment/Procedure: _____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards.

Date: ____/____/____ Initial _____

I hereby consent to and authorize _____ to perform the following procedure:
Student Name

Treatment/Procedure: _____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards.

Date: ____/____/____ Initial _____

COVID-19 ACKNOWLEDGEMENT OF RISK FORM

As a participant in the Student Clinic at Lotus Professional College I accept the following conditions of participation, and I acknowledge that I have been informed of the general nature of the risks involved in this activity, including, but not limited to slips and falls, and contracting diseases such as COVID-19, also known as the coronavirus disease.

COVID-19 is a pandemic of respiratory disease that spreads from person-to-person. COVID-19 can cause mild to severe illness; most severe illness occurs in older adults. Nevertheless, people of all ages are at risk of contracting COVID-19, and people with severe chronic medical conditions including, but not limited to, heart disease, lung disease, and diabetes, are at a higher risk of developing serious COVID-19 illness. I also understand that, at this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.

Symptoms of COVID-19 include, but are not limited to, fever, cough, and shortness of breath. Reported illnesses may range from very mild (including some with no reported symptoms) to severe, including death. If I feel sick, I agree not to go to the clinical facility and that I will stay home for the period of time recommended by the Centers for Disease Control and Prevention (the "CDC"), which is typically two weeks, but may be longer if I am still symptomatic or contagious. During this period of quarantine, I may leave the house to receive medical attention if necessary.

Additionally, while participating in the clinic, I agree to take all necessary precautions recommended by the CDC to prevent the spread of COVID-19, including but not limited to, washing my hands thoroughly and often, avoiding large gatherings, wearing a mask to cover my mouth and nose, and avoiding public transportation, ride-sharing, or taxis.

I agree to abide by any and all specific requests by the College and the clinical facility for my safety and the safety of others, as well as any and all of the College's and the clinical facility's rules and policies applicable to all activities related to this program. I understand that the College and the clinical facility reserve the right to exclude my participation in this program if my participation or behavior is deemed detrimental to the safety or welfare of others.

In consideration for being permitted to participate in this clinic, and because I have agreed to assume the risks involved, I hereby agree that I am responsible for any resulting personal injury or illness which may occur as a result of my participation or arising from my participation in this program, unless any such personal injury or illness is directly due to the negligence of the College and/or the clinical facility. I understand that this Assumption of Risk form will remain in effect during any of my subsequent visits and program-related activities, unless a specific revocation of this document is filed in writing with the Lotus Professional College, at which time my visits to or participation in the program will cease.

In case an emergency situation arises, please contact _____
(name) at _____ (phone number).

I acknowledge that I have read and fully understand this document. I further acknowledge that I am accepting these personal risks and conditions of my own free will.

_____ I represent that I am 18 years of age or older and legally capable of entering into this agreement.

Lotus Professional College Volunteer Protocols

- There will be no cash or check payments accepted. Only Card.
- Card information and email will be taken via phone when scheduling an appointment.
- Your card will be charged the following business day and a receipt will be emailed to you.
- No eating or drinking while in the building
- Masks will be required at all times , this includes when you are face down on the massage table
- No loitering in the building.
- 5 minutes prior to your appointment time, please come to the main door to be checked in (checking in will include a temperature check and wellness questions).
- Once inside go directly to the assigned door to meet the clinic supervisor (you will be told which door to go to during check in)
- Since all consultations are done table side, we cannot accommodate volunteers that are more than 10 minutes late.
- Only exit out assigned door when facial is over.
- You may call to schedule another appointment

Participant's printed name

Date

Participants Signature