**Consent Form**

I, Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_ to Tattoo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on my: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tattoo Session Cost: \_\_\_\_\_\_\_\_\_deposit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Final Balance: \_\_\_\_\_\_\_\_

Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_I am not currently under the influence of/ or intoxicated on alcohol or drugs.

\_\_\_\_\_\_I am NOT pregnant

\_\_\_\_\_\_ I understand that Tattoo inks have NOT been approved by the federal Food and Drug Administration and have unknown health consequences.

\_\_\_\_ I certify that I am at least 18 years of age, I understand and acknowledge the significance and consequence of the foregoing release and hereby assume full responsibility for my actions. I understand that tattoos are permanent and may require removal that can lead to scarring. I understand and agree to follow all aftercare instructions given to me by my artist, and I understand that not following instructions can lead to infection or damage to skin. I understand that it is my responsibility and mine alone to contact my artist directly with any questions I may have.

\_\_\_\_\_\_I am not currently taking any medications, If any medication has been taken in the past 2weeks please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK ANY OF THE FOLLOWING THAT HAVE APPLIED TO YOU OVER THE PAST 2 YEARS

|  |  |
| --- | --- |
| * HEMOPHILIAC
 | * SKIN SENSITIVITY
 |
| * CURRENTLY NURSING
 | * CANCER
 |
| * DIABETIC
 | * HIV/AIDS
 |
| * HYPOGLECEMIC
 | * HEPATITIS
 |
| * RECEIVING DIALYSIS
 | * PRONE TO FAINTING
 |
| * ANEMIC
 | * HERPES
 |
| * JAUNDICE
 | * CARDIAC VALVE DISEASE
 |
| * LATEX ALLERGY
 | * OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

I certify under penalty of perjury that ALL the information given above is to the best of my knowledge. By signing below I give Westfall Tattoo LLC permission to use any photographs for promotional purposes with no compensation. I hereby release Westfall Tattoo, Nic Westfall and/or David Garner and all of its associates and contractors (GUEST ARTIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) from all liabilities, claims, demands, injury, and grievance arising from or connected in any way with my tattoo or the procedures and conduct used to apply my tattoo.

I acknowledge that it is not reasonably possible for the representatives or owner of Westfall Tattoo LLC to determine whether I might have an allergic reaction to the pigments or processes used in my tattoo, and I agree to accept the risk that such reaction is possible.

I have been informed of the possibility of infection. I understand it is my responsibility to keep the area clean by following all care instructions given to me by my artist. I have been informed of the signs and symptoms of infections including, but not limited to: redness, swelling, tenderness, elevated body temperature and purulent drainage from the procedure site. Please contact your artist and/or seek medical care if any of the above exist after a procedure.

**I, (Client Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Release all liabilities on (Date): \_\_\_\_\_\_\_\_\_\_\_\_**

**DO NOT WRITE BELOW: OFFICIAL USE ONLY (TOOLS LOG)**

Date: \_\_\_\_\_\_\_\_\_\_\_ Load #: \_\_\_\_ Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Load #: \_\_\_\_Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Artist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I have read and reviewed all information on this form.

|  |  |  |
| --- | --- | --- |
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