**[Your Studio Name]**
[Street Address], [City], [State] [ZIP]
[Phone] · [Email] · [@instagram]
[Health department permit # 000000]

# TATTOO CONSENT & RELEASE

Complete before every tattoo session · one form per session

## 1 CLIENT INFORMATION

| | | | |
|---|---|---|---|
| **Full legal name** | | **Date of birth** | ____ / ____ / _____ |
| **Mobile phone** | | **Email** | |
| **Street address** | | | |
| **Emergency contact** | Name, relationship, phone | | |

| | |
|---|---|
| **Age** | ☐ I am 18 or older and the photo ID I am showing is my own and valid. |
| **ID check (studio)** | ☐ Driver's license ☐ State ID ☐ Passport ☐ Military ID ☐ Other: _____ · Expires ____/____/_____ · ☐ Birth date matches · ☐ Photo matches · Checked by: _____ |

## 2 HEALTH QUESTIONS

Answer every question. A Yes does not always mean we cannot tattoo you; it helps your artist decide how to work safely, or whether to wait. Your answers stay confidential.

| # | Question | Yes | No |
|---|---|---|---|
| 1 | Are you pregnant, trying to become pregnant, or nursing? | ☐ | ☐ |
| 2 | Do you take blood thinners, or have you had aspirin or ibuprofen in the last 24 hours? | ☐ | ☐ |
| 3 | Do you have a bleeding or clotting disorder (for example hemophilia)? | ☐ | ☐ |
| 4 | Do you have diabetes? | ☐ | ☐ |
| 5 | Do you have a heart condition, a pacemaker, or high blood pressure? | ☐ | ☐ |
| 6 | Do you have epilepsy or seizures, or have you ever fainted or felt dizzy around needles or blood? | ☐ | ☐ |
| 7 | Do you have an immune condition or take medicine that slows healing (chemotherapy, oral steroids)? | ☐ | ☐ |
| 8 | Do you form keloids or raised, thick scars? | ☐ | ☐ |
| 9 | Are you allergic to latex? | ☐ | ☐ |
| 10 | Are you allergic to pigments, metals, tape, adhesives, soaps, antiseptics, ointments or lidocaine? | ☐ | ☐ |
| 11 | Do you have eczema, psoriasis, a rash, raised moles, sunburn, cuts, or a recent laser or peel near the area? | ☐ | ☐ |
| 12 | Are you taking, or have you taken in the past 12 months, isotretinoin (Accutane) or prescription retinoids? | ☐ | ☐ |
| 13 | Have you had a reaction to a tattoo, permanent makeup or piercing before? | ☐ | ☐ |
| 14 | Have you had alcohol, cannabis or recreational drugs in the last 24 hours? | ☐ | ☐ |
| 15 | Are you feeling unwell today (cold, flu, fever, cold sore near the area)? | ☐ | ☐ |
| 16 | Is there anything else about your health, medications or skin your artist should know? | ☐ | ☐ |

**If you answered Yes to any question, give details (condition, medication, date):**



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