

Physician Authorization for Pedicure

Patient's name: _____

Technician: Judy Webb ANT,MNT
Suite A Santa Cruz, Ca. 95062 831-724-3099

at Salon: Judy's PediCare at 1515 Capitola Rd

I grant permission to provide cosmetic services to my patient who is under my monitored health care with the following medical problem: (Marked or otherwise written.)

Minimal Neuropathy (Decreased or distorted sensation in their hands or feet)

Controlled Diabetes

Healing Injury/lesion

Minimal Circulation deficits or Vascular compromise

Fungal nails (treated)

Surgical site

Ingrown nails without infection

Blood Borne illness (controlled)

Cosmetic allergies or other allergies

Other medical issues or special instructions _____

VERY IMPORTANT: If any injury or new medical problem is noted or suspected injury occurs while performing services on my patient, you must immediately contact this office to report the nature of the problem (Mark preference)

By phone call to: _____ By text to: _____ Other: _____

Instruct the patient set up an immediate appointment. If you cannot reach my office immediately, direct the patient to the emergency room or clinic and notify our office the medical facility where you referred him or her.

If an injury occurs, clean the wound with soap and water, swab with 70% alcohol, Betadine or an antiseptic approved by your State Board of Cosmetology. Bandage the area with a sterile dressing.

Physician's Signature Authorization _____ Date: _____