Physician Authorization for Pedicure

Patient's name: _____

Technician: _Judy Webb ANT,MNT_____ at Salon: ___Judy's PediCare at 1515 Capitola Rd Suite A Santa Cruz, Ca. 95062 831-724-3099_____

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)

Minimal Circulation deficits or Vascular compromise	Controlled Diabetes	Healing Injury/lesion
Ingrown nails without infection	Fungal nails (treated)	Surgical site
Cosmetic allergies or other allergies	Blood Borne illness (controlled)	

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.

_____ Date: _____

Physician's Signature Authorization