THE QUEENS INSTITUTE FOR SKIN DISEASE AND ANTI-AGING

Patient Information, Consent, and Waiver

IV Drip Therapy Treatments

Patient Information:

Name: ____

Date of Birth: ____

Address: ____

Phone Number: ____

Email: ____

Emergency Contact: ____

Emergency Contact Phone: _____________________________________

(… continued on next page)

Medical History:

Please check any conditions you currently have or have had in the past:

- [ ] Allergies (please specify): ____
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Thyroid disorder
- [ ] Blood clotting disorder
- [ ] Other (please specify): ____

List any medications you are currently taking (prescription, over-the-counter, supplements):

____

____

Do you have any known allergies (medications, foods, latex, etc.)? Please specify:

____

____

(… continued on next page)

IV Treatment Information:

The IV treatment(s) I am receiving are for the purpose of:

____

____

I understand that the IV treatment(s) may include hydration, vitamins, minerals, and other nutrients, and are intended for general wellness purposes.

Consent:

I have been informed about the nature of the IV treatment(s), including their purpose, potential benefits, and risks, which may include but are not limited to allergic reactions, infection, vein irritation, or other complications.

I understand that the IV treatments are not a substitute for medical advice, diagnosis, or treatment from a licensed healthcare professional.

I consent to receive the IV treatment(s) voluntarily and understand that I have the right to ask questions and seek clarification at any time.

(… continued on next page)

Waiver:

I hereby release and discharge The Queens Institute for Skin Disease and Anti-Aging, the Queens Med Spa, The Queens Health Centre, its staff, and affiliates from any and all claims, demands, causes of action, damages, or liabilities which may arise out of or in connection with the IV treatment(s) provided, except those caused by gross negligence or willful misconduct.

I acknowledge that I have read and understand this form in its entirety, and I have had the opportunity to ask questions and receive satisfactory answers.

Signature:

Patient Signature: _______________________

Date: _______________________