



Consent Form (Scarification)

Studio: _____

Artist: _____

Client: _____

Appointment: _____ at _____

Client Information

Phone: _____

Email: _____

Date of Birth: _____

Procedure Details

• **Technique:**

- ☐ Cutting
- ☐ Skin removal
- ☐ Strike branding
- ☐ Other heat branding: _____

Placement: _____

Design Size: _____

☐ I approve the final design, size, and placement as drawn or stenciled on my skin.

Age and ID

☐ I confirm I am 18 or older and have shown a valid government photo ID. I understand this studio does not perform scarification on minors.

Please read and initial each item

- ☐ I understand scarification is permanent. It can't be removed or reversed, and options to change or hide it later may be limited.
- ☐ I understand the final result depends on how my skin scars. Lines may heal raised, flat, wider, thinner, lighter, darker, or uneven. Parts of the design may heal less visible than expected. The exact result can't be predicted or guaranteed.
- ☐ I understand healing can take months, and the scar may keep changing in color and texture long after the surface has closed.
- ☐ I understand that a history of keloids or raised (hypertrophic) scars raises my risk of thick, raised scarring. I have answered the screening question about this below.
- ☐ I understand risks include pain, bleeding, infection, excess scarring, keloids, skin color changes, changes in nerve sensitivity, and a result that doesn't match the design.
- ☐ I will follow the aftercare instructions from my artist. I won't irritate, pick, scrub, or otherwise work the wound to change how it scars unless my artist tells me to and explains how.
- ☐ I will seek medical care if I see signs of infection, such as spreading redness, heat, pus, or fever.
- ☐ I am not under the influence of alcohol or drugs.
- ☐ I had the chance to ask questions before the procedure.
- ☐ I consent to photos of the design and the work for my client record.
- ☐ *(Optional)* I consent to photos for the artist's portfolio and marketing. I can say no without it affecting my procedure.
- ☐ I have had time to think about this decision. It is my own, and I consent to the procedure described above.

Health and Safety Screening

• Keloid or raised (hypertrophic) scarring history?

- ☐ Yes
- ☐ No

• Blood-thinning medications or bleeding disorder?

- ☐ Yes
- ☐ No

Don't stop a prescribed medication without talking to your doctor.

• **Diabetes or a condition that slows healing?**

☐ Yes

☐ No

• **Immune system conditions or immunosuppressant medications?**

☐ Yes

☐ No

• **Accutane (isotretinoin) in the past 12 months?**

☐ Yes

☐ No

• **Pregnant or nursing?**

☐ Yes

☐ No

• **Pacemaker or other implanted medical device?**

☐ Yes

☐ No

• **Skin conditions at or near the placement?**

☐ Yes, describe: _____

☐ No

• **Known allergies (latex, topical products, other)?**

☐ Yes, describe: _____

☐ No

Other health notes: _____

☐ I certify that I have answered these questions truthfully and to the best of my knowledge.

Client Signature: _____ **Date:** _____

Artist/Staff Signature: _____ **Date:** _____

**Prefer not to print? Run this form digitally — clients sign on their phone before they arrive.
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