

REACTION FORM

Salon Name: _____ Date: _____

Phone Number: _____ Email: _____

Client Name: _____

1. Name of Product used:

2. Batch Number of the product(s) used

3. Please describe how you used the products

4. Were you using any other product?

YES NO

If YES, provide details

5. How many times did you use the product before you experienced a problem?

6. Where did the reaction occur?

7. Did the reaction occur during a salon treatment?

YES NO

Treatment received: _____

Date of treatment: _____

Name of salon: _____

Name of therapist: _____

8. Describe the reaction you experienced

9. For how long did the reaction occur? _____

10. Did you see a Doctor?

YES NO

If YES, when did you see the Doctor: _____

Did the doctor prescribe any medication?

YES NO

If YES, what were you prescribed?

11. Have you stopped using the product?

YES NO

12. Have you ever reacted to any other products?

YES NO

If YES, please tick the following categories that apply

Cosmetics

Foods

Medicines

Clothing

Soaps

Shampoos

Hair Dyes

Perfumes

Plants

Jewellery

If you ticked any of the above, please provide details

13. Have you had any cosmetic procedures done recently?

YES NO (e.g. Botox Laser IPL)

If YES, please provide details

14. Do you have any allergies to seafood or Iodine

YES NO

If YES, please provide details

15. Are you currently taking any medication?

YES NO

If YES, please provide details

16. Please provide as many photos as possible.

17. Please provide any other information you may think to be relevant

Signature

Date: _____