



Beauty Bus Foundation  
11301 Olympic Blvd. # 303  
Los Angeles, CA 90064  
phone 310.287.1272 | fax 310.287.1271

**BEAUTY BUS FOUNDATION**  
**DOCTOR RELEASE FORM**

**Please return completed release form to Beauty Bus Foundation**  
**via one of the following:**

**Mail: 11301 Olympic Blvd. #303, Los Angeles, CA 90064**

**Fax: 310-287-1271**

**Email: [beauty@beautybus.org](mailto:beauty@beautybus.org)**

**Doctor:**

**Your patient, \_\_\_\_\_, has requested the services of the Beauty Bus Foundation.**

**The Beauty Bus Foundation is a non-profit organization dedicated to enhancing the quality of life for homebound, chronically and terminally ill people and their primary caregivers by bringing beauty into their lives. We provide at-home beauty and grooming treatments, free of charge, to empower our clients, help them maintain dignity and give them a small departure during a difficult time.**

**Services are performed by trained beauty professionals who are accompanied on each home visit by another Beauty Bus volunteer, the Beauty Buddy. Each service lasts approximately one-hour.**

**Beauty Bus services clients with: ALS (Lou Gehrig's Disease), Cancer, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Spinal Cord Injuries, and Stroke. Clients and caregivers are seen at the same visit and can determine when to use their four beauty treatments throughout each year, subject to volunteer availability.**

**Please complete this form and return it to Beauty Bus so that we can set up a visit for this client and his or her primary caregiver.**

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I represent that:

Patient Name: \_\_\_\_\_

meets the qualifications for Beauty Bus services as outlined above and is authorized and released to receive the following treatment(s) in his/her home based on his/her health condition (PLEASE CHECK ALL THAT APPLY):

- \_\_\_\_\_ Hair cut, styling and/or blow dry (no hair washing)
- \_\_\_\_\_ Makeup application
- \_\_\_\_\_ Manicure
- \_\_\_\_\_ Mini Facial
- \_\_\_\_\_ Pedicure

Does the patient have any co-existing communicable diseases that would affect his/her ability to receive a Beauty Bus treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Does the patient have any allergies to products or any allergies that would affect Beauty Bus services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is there anything else that will affect Beauty Bus services of which Beauty Bus should be aware? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Print Physician Name: \_\_\_\_\_

Medical License Number: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Date: \_\_\_\_\_