

BEAUTY BUS MEDICAL RELEASE FOR IN-HOME SERVICES



Beauty Bus Foundation
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Santa Monica, CA 90405
phone 310.392.0900 | fax 310.392.0907
www.beautybus.org

BEAUTY BUS FOUNDATION
MEDICAL RELEASE FORM FOR IN-HOME SERVICES

NOTE: This form may be filled out by any licensed medical professional within the scope of his/her practice.

Medical Professional:

Your patient, _____, has requested the services of the Beauty Bus Foundation.

The Beauty Bus Foundation is dedicated to enhancing the quality of life for chronically or terminally ill people and their caregivers by bringing beauty into their lives. Beauty Bus strives to empower our clients, help them maintain dignity, and give them respite during difficult times.

Beauty Bus provides in-home beauty services to individuals who are otherwise unable to access a salon or spa due to the following diseases or conditions: ALS (Lou Gehrig's Disease), Cancer, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Spinal Cord Injuries, Stroke, and other select Neuromuscular and Motor Neuron Diseases.

Each service lasts approximately one hour. If there is a caregiver, he or she must be present and available during the client's Beauty Bus visit. Please complete this form and return it to Beauty Bus so that we can set up a visit for your patient and his or her caregiver.

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I, _____ (Print Name of Medical Provider), represent that that:

Patient Name: _____

- has one of the following diseases or conditions: (please check)

- _____ ALS (Lou Gehrig’s Disease) _____ Cancer
- _____ Muscular Dystrophy _____ Parkinson’s Disease
- _____ Spinal Cord Injuries _____ Stroke
- _____ Multiple Sclerosis
- _____ Other Neuromuscular and Motor Neuron Disease (Please specify):

- and that his/her condition prevents him/her from being able to access a salon or spa.
- I also authorize and release _____ (patient name) to receive the following treatment(s) in his/her home based on his/her health condition (PLEASE CHECK ALL THAT APPLY):

- _____ Haircut, Styling and/or Blow Dry (no hair washing, no color)
- _____ Facial Treatment (no waxing)
- _____ Makeup Application
- _____ Manicure
- _____ Pedicure

Beauty Bus recognizes the sensitivity of entering a patient’s home and wants to be sure everyone is safe and comfortable.

How does the patient react to new people in new situations?

Has the patient had violent episodes of the type that might be triggered by the provision of in-home beauty services?

Are there any concerns about the patient harming himself/herself or others, especially given that in-home beauty services involve professional tools, including but not limited to cutting shears, scissors, clippers and files?

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Does the patient have any allergies to products or any allergies that might be affected by in-home beauty services? ____ Yes ____ No

If Yes, please explain: _____

Is there anything else that Beauty Bus should be aware of that might affect Beauty Bus's ability to provide in-home beauty services to this patient?

Print Medical Professional Name: _____

Medical Professional License Number: _____

Medical Professional Signature: _____

Phone: _____

Date: _____

Please return completed release form to Beauty Bus Foundation
via one of the following:
Mail: 2716 Ocean Park Blvd., Suite 1062, Santa Monica, CA 90405
Fax: 310-392-0907
Email: beauty@beautybus.org