

Contraindications & Precautions & Warnings

Please initial each line, showing you understand these health conditions are contraindications which prohibit you from using the Invisa-Red Laser:

____ Pregnant or nursing. There is no evidence of harm to an unborn child however there have been no safety tests either.

____ Current infection or acute symptoms such as a fever

____ Hemorrhagic disease or vascular ruptures, aneurysm

____ Immune system dysfunction: Cancer, Leukemia, Hemophilia, etc.

____ Autoimmune diseases such as Lupus, Scleroderma, Vitiligo

____ Pacemakers or other electro-stimulation devices that are surgically implanted

____ Light Sensitive Epilepsy

____ Hypertension

____ Heart Disease

____ Skin inflammation due to allergic or pathogenic issue

____ Severe varicose veins

____ Active skin infections, open lesions, hives, herpetic lesions, cold sores

____ Tattoos and permanent make-up in the area of treatment

____ Use of Accutane, tetracycline, St. John's Wart, or photo sensitizing drugs within 6 mos.

____ Use of essential oils that are photo sensitizing

____ Insulin dependent: **consult your physician** (Glucose levels could fluctuate)

____ **Children under 18 years old are not allowed to use this device**

I, _____, have read, understand, and initialed all of the above contraindications. By signing below, I **acknowledge that I currently have none of the above health issues** that would keep me from participating in Invisa-Red Laser Sessions.

Date: _____

Signature: _____