



BOTOX Consent Form

Please read the following information completely before signing below

BOTOX Cosmetic is indicated for the temporary improvement in the appearance of moderate to severe frown lines in people age 18 to 65. It is being used for cosmetic appearance only and no medical benefit is implied.

Patients with any of the following problems should NOT use BOTOX cosmetic:

- Infection at the proposed site
- neurological disorders such as ALS, myasthenia gravis, Lambert-Eaton Syndrome or Alzheimers
- Are breast feeding, pregnant or planning to get pregnant soon
- Are taking any medicines to treat heart rhythm problems
- Are taking any antibiotics to treat infection, such as gentamicin, tobramycin, clindmycin and lincoimycin
- Have any history of an allergic reaction to the ingredients in BOTOX Cosmetic

Possible Side effects include but are not limited to:

- Localized Pain and inflammation
- Bleeding/Bruising at site of injection
- Muscle weakness
- Headache
- Respiratory Infection
- Flu syndrome
- Temporary eyelid droop or facial asymmetry
- Nausea
- Allergic reaction including hives, shortness or breath, swelling or anaphylaxis.

I have read all the above information and understand the risks and benefits of using BOTOX Cosmetic and wish to proceed with the injections. I will not hold the provider responsible if any of the above side effects occur as I understand it is a risk involved with using this product.

Patient Signature _____

Printed name _____

Date _____ Time _____