

LA BELLA BABY SPA

Dubai Healthcare City, Building 25, Office # 105

Tel: +971 56 907 6274 | Email: info@labellababyspa.com | Web: www.labellababyspa.com

Information and Consent Form

MR No:

Parent Name:	
Name of the child	Gender:
Date of Birth	Nationality
Age	Emirates ID
Email	Phone:
Emergency Contact	City
Type of visit: <input type="checkbox"/> First Visit <input type="checkbox"/> Follow-up	
Treatment	
How did you hear about us? <input type="checkbox"/> Instagram <input type="checkbox"/> Through a friend <input type="checkbox"/> Other	
<input type="checkbox"/> Facebook <input type="checkbox"/> Google <input type="checkbox"/> Tik Tok <input type="checkbox"/> Advertisement	
I confirm for you to use my baby's photos/videos in your social media.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	

Does your child have current injuries?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has your child been recently hospitalized?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does your child take any medications?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does your child have any allergies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
How is your child's skin condition?	<input type="checkbox"/> NORMAL	<input type="checkbox"/> SENSITIVE
Does your child have any medical issues?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did your child have any surgery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

- I hereby consent to the service of Hydrotherapy/Floating and Infant/Therapeutic Massage by the Registered Massage Therapist and/or Registered Nurse at La Bella Baby Spa.
- I authorize the use of Dermatology tested lotions/oil on my child's body.
- I understand, as in all health care, in the practice of Massage Therapy and Hydrotherapy/Floating there can be risks to treatment, including but not limited to, bruising, light headedness or dizziness.
- I understand that this is an alternative treatment and if there are any medical concerns, I need to talk to my physician.
- I confirm that all information I provided on this form is true and accurate.
- I agree that healthcare provider(s) involved in my care at this facility will access my health information through the Health Information Exchange System (NABIDH) in accordance with the Laws of the United Arab Emirates, Emirate of Dubai Legislation and Dubai Health Authority Policies
- I have read, understood, and agreed to obligations as listed above.

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Parent Name:

Parent Signature: ||PARENTSIGNATURE||

Date: