LOLITA M.
DOMINGUE
MARRIAGE & FAMILY THERAPY

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Informed Consent for Phototherapy

Although light stimulation devices used here are generally safe, I understand the following information about potential hazards may exist and no claim about guarantees of effectiveness is made. Light stimulation devices are not recognized as medical devices and all participation with them is strictly voluntary and experimental. Although some research findings are known, there is presently not enough for it to be recognized as standard treatment.

_____Yes _____No Do you have a history of photosensitive seizures?

_____Yes _____No Do you have a life-threatening illness?

_____Yes _____No Are you having suicidal thoughts?

_____Yes _____No Are you taking medications that are known to have photosensitive side effects? *

_____Yes _____No Do you feel prone to violence or homicide?

_____Yes _____No Do you have medical conditions that are important to disclose here? If so, what? _____

_____

* If so, check with your physician to determine if these side effects are significant enough to recommend avoiding low brightness (40 watts) light stimulation into the eyes.

✦ The healing process sometimes involves provoking discomfort before relief is achieved.
✦ Delayed emotional and physical reactions from the exposure to light stimulation may occur.
✦ Bright blue light has been found to be potentially hazardous to the retina.
✦ No claims are made for sexual enhancement.

I understand and consent to have my child, _____ , participate in phototherapy.

I understand and consent to participate in phototherapy.

_____
Print Name

_____ _____
Signed Date

_____ _____
Witness