Makeup Consent Form

NAME: _____ PHONE # _____
ADDRESS: _____
EMAIL: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

- ☐ VIRAL BACTERIAL FUNGAL INFECTIONS
- ☐ SKIN CONDITIONS
- ☐ CONJUNCTIVIS
- ☐ RECENT SCARRING
- ☐ UNDIAGNOSED LUMPS SWELLING
- ☐ COVID

PLEASE CHECK IF APPROPRIATE

1. WHAT IS YOUR SKIN TYPE? ☐ NORMAL ☐ OILY ☐ DRY ☐ COMBINATION

2. WHAT IS YOUR SKIN TONE? ☐ FAIR ☐ MEDIUM ☐ LIGHT ☐ DEEP

3. WHAT IS YOUR SKIN'S UNDERTONE? ☐ NEUTRAL ☐ WARM ☐ COOL

DO YOU HAVE ANY ALLEGIERS? ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

_____

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO

HAVE YOU EVER EXPERIENCED A REACTION TO ANY MAKEUP OR SKINCARE PRODUCTS? ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

_____

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DO YOU HAVE ANY SKIN CONCERNS YOU WOULD LIKE ADDRESS?

_____

IS THIS LOOK FOR EVENT OR SPECIAL OCCASION? ☐ YES ☐ NO

ARE THERE ANY SPECIFIC COLOURS OR TECHNIQUES YOU WOULD LIKE TO INCLUDE IN YOUR MAKEUP?

_____

ARE YOU CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO

IF YES, PLEASE LIST:

_____

WHAT COVERAGE ARE YOU LOOKING FOR?

☐ LIGHT
☐ MEDIUM
☐ Full

Do you have any of the following conditions:

AIDS/HIV: ☐ HERPES/COLD SORES: ☐ HEPATITIS: ☐ ECZEMA: ☐ WARTS: ☐ SHINGLES: ☐ CYSTIC ACNE: ☐
PSORIASIS: ☐ ROSACEA: ☐ AUTOIMMUNE DISORDER: ☐ CURRENT CANCER TREATMENTS: ☐
OTHER MEDICAL CONDITIONS NOT LISTED:_____

_____

BY SIGNING THIS FORM, I CONSENT TO MAKEUP AND SKINCARE APPLICATIONS. I ALSO CONSENT TO THE USE OF MY MAKEUP PHOTOS FOR MARKETING PURPOSES. THESE INCLUDE BUT ARE NOT LIMITED TO FINISHED MAKEUP LOOKS & BEFORE AND AFTER PHOTOS.. BY SIGNING THIS FORM I ATTEST THAT I HAVE COMPLETED THIS FORM TO THE BEST OF MY ABILITIES AND HAVE INFORMED THE MAKEUP ARTIST OF ANY AND ALL ALLERGIES OR MEDICAL CONDITIONS THAT COULD EFFECT THE SERVICES RENDERED..

_____ _____

Client Signature Date:

Thank You For Your Business