



BROW LAMINATION/ LASH LIFT/ TINT

Client Consent Form

Name: _____ Sex: _____ D.O.B _____

Address: _____

Phone: _____ Email: _____

Occupation _____ How did you hear about us? _____

_____ I agree to have an eyelash lift, brow lamination, eyelash tint, and/or retouching performed on my natural eyelashes. By completing this agreement, I authorize my technician to do an eyelash perm, brow lamination, or eyelash tint.

_____ I understand that there are dangers involved with eyelash perming, brow lamination, and/or eyelash tinting. I also realize that eye irritation, eye pain, eye itching, discomfort, and, in rare situations, eye infection or blurriness may develop as a result of the surgery.

_____ I agree that if I experience any of these medical issues, I will inform my technician and seek medical attention at my own expense.

_____ I understand that the instruments, tapes, cleansers, eye gel pads, adhesives, and removers used may hurt my eyes/brows or necessitate follow-up care by a physician, even if my technician perms my lashes/brows using the right procedure.

_____ I understand that, depending on the sensitivity of my skin during the brow lamination technique, certain slight but usual adverse effects may occur and will resolve within 24 hours. These symptoms may include minor tingling, slight redness from hair combing, and slight warmth in the affected area.

_____ I understand that this agreement will stay in place for the duration of the current operation and all future procedures performed by my technician.

_____ I assume full responsibility for any reaction that may result from undeclared sensitivities or allergies.

_____ I understand and consent to having my eyes closed for the duration of the process.

_____ I understand that if I have any questions or issues, I will speak with my lash/brow technician.

_____ I will remove any contact lenses prior to the start of the treatment.

CONSULTATION FORM

Medical History:

Do you have or have you ever had any of the following conditions?

If so, please check the box below

Lash Lift Contraindications

Dry Eye Syndrome

Chemotherapy

Sensitive eyes

History Of Eye infection

Ocular Rosacea

Sjorgen's Syndrome

Brow Lamination Contraindications

Alopecia

Chemotherapy

Eczema

Psoriasis

Super Sensitive Skin

Sunburn

Wounds In Treatment Area

Recent Facial Treatment

Retinol, AHA, BHA etc.

Do you have any allergies to tape, fumes, or eye remover?

No

Yes

Past allergy or sensitivity to lash lift, tinting, or brow lamination?

No

Yes

Are you breastfeeding or pregnant?

No

Yes

Do you wear contact lenses?

No

Yes

Do you use any type of eye drops?

No

Yes

Do you use a sunscreen or moisturiser containing oil around your eyes?

No

Yes

List any usual drugs or supplements you take:

Have you had lash extensions/lash lifts or brow lamination recently?

No

Yes (If Yes, when?)

Have you used semi-permanent cosmetics (brows, liner) recently?

No

Yes (If Yes, when?)

I consent to having my eyes covered and closed for the process No Yes

With your signature below, you consent to the following:

I am over the age of 18 and I have filled out this form accurately and to the best of my knowledge. I consent to notify the technician of any modifications to the above information. I concur that I do not have any condition(s) that would render the recommended treatment inappropriate. I agree to release my technician and employer from all liability for any injury or damages resulting from a misrepresentation of my health.

Client Name (printed)

Client Name (Signature)

Date

Esthetician (printed)

Esthetician(Signature)

Date