

I authorize my Xtreme Lashes[®] Trained Professional, _____ (Professional Name/Business Name), to perform the semi-permanent eyelash extension procedure. I understand this procedure requires individual synthetic eyelashes to be adhered to my own natural lashes. I understand that it is my responsibility to remain still during the application and to keep my eyes closed during the entire process until otherwise advised. I have been fully informed as to the methods and procedures concerning the semi-permanent eyelash extension application. The known risks of the cosmetic procedure I have chosen have been disclosed to me. Some cases may result in complications, such as transient eye redness and irritation and allergic reaction to the adhesive, under eye gel patches or any other products used. If at any time I am uncomfortable with the eyelash extension procedure, I will inform the stylist and s/he will gladly rectify the problem, including ending the session if I (or the stylist) wish. If the stylist is uncomfortable applying lashes to me, s/he will discuss his/her concerns with me and may end the session if necessary. It has been represented to me that no guarantees, warranties, promises, commitments or other statements as to the results of this service have been made, and I acknowledge that I have received no particular representations or guarantees, and I am consenting to the procedure at my own risk. I have revealed or disclosed on the Client Registration & History Form and the Client Consultation & Design Form all conditions and circumstances regarding my health and health history, medications being taken, and any past reactions to products used or medications taken. Additional conditions may occur or be discovered during or after the procedure, which could affect my ability to tolerate the procedure.

I understand the longevity of my eyelash extensions requires my careful maintenance. I understand basic makeup application and normal lifestyle can resume after the application. However, during the first 3 hours after the application I should avoid replacing contact lenses, water, liquids, steam, excessive heat, and cosmetics (skincare, mascara, etc.) for extended longevity and flexibility of my eyelash extensions. I also understand that even after the first 3 hours, I need to avoid the following activities: excessive swimming, sauna, steam rooms, pulling on lashes, using oil-based, or waterproof cosmetics. Using mechanical curlers or crimping lashes in any way is not recommended while wearing eyelash extensions.

I, as herein signed, release, give up, acquit, and discharge my Xtreme Lashes[®] Trained Professional or anyone affiliated with my Xtreme Lashes[®] Trained Professional including any partnership, corporations, or company associated with said individual from any claims or damages of any nature. I agree to pay any costs of legal services necessary to further effect or confirm said release. I further agree that this release shall be in contemplation of any possible damages, either known or unknown at the signing of this Waiver and Release Form, and said damages are specifically waived following the signing of this waiver and release form. I further agree that in the event any litigation ensues, it shall be placed before the American Arbitration Association for resolution. I agree that in the event a decision is determined in favor of one party over the other, the prevailing party shall be entitled to reasonable attorney fees and costs as set by the arbitrator. I further agree to hold my Xtreme Lashes[®] Trained Professional and Xtreme Lashes LLC nameless and harmless from any and all damages. I release my Xtreme Lashes[®] Trained Professional from any responsibility for pre-existing conditions I have not revealed, or any consequential change to those conditions that arises subsequent to the procedure. I understand that I am responsible for any medical treatment I may need to receive as a result of getting this procedure. I accept full responsibility for these and any other complications, which may arise or result during or following the eyelash extension procedure(s), which are to be performed at my request.

Please read, check, sign, and date the statements below and on the following page to indicate that you have read, understand, and accept the following statement:

I, the client herein signed, certify that I have read and had explained to me and fully understand the above Waiver and Release Form. I certify that I have consulted with an Xtreme Lashes[®] Trained Professional and have read all applicable literature given to me. I have completed the Client Registration & History Form and the Client Consultation & Design Form to the best of my knowledge. I accept the explanation of potential complications and risks described herein. I certify I am of sound mind, and I am fully capable of executing this waiver and release form for myself. I, the undersigned client, acknowledge and fully understand that there might be other unknown risks not reasonably foreseeable at this time. I, the client herein signed, for the purposes of documentation, hereby consent to "before and after" photographs.

I, the client herein signed, hereby give Xtreme Lashes, LLC, and its affiliates, the absolute right and unrestricted permission to take, use, and display photographic images of me, through any form of media (print, digital, electronic, broadcast, or otherwise) at any location for art, advertising, media release news articles, marketing, publicity, archival, or any other lawful purpose. I waive any right to royalties or other compensation arising from or related use of photographic images of me. I release and agree to hold harmless Xtreme Lashes, LLC and its affiliates from any liability in connection to taking or using said images. (Optional)

Date: _____

Client Full Name: _____ Client Signature: _____

Address/City/State/Zip Code: _____ Email: _____

Home Phone Number: _____ Cell Phone Number: _____

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Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Business #: _____ Cell #: _____ Fax #: _____

Email: _____

Facebook Account: _____ Twitter Name: _____

How may we contact you regarding scheduled appointments or specials? Check all that apply:

- Text Message
 Email
 Home Phone
 Business Phone
 Mobile
 Morning
 Afternoon
 Evening

When do you prefer to be contacted? _____

Birthday: _____ Anniversary: _____

Sex: Female Male Age: _____ Occupation: _____

Emergency contact name: _____

Emergency contact phone #: _____ Relationship to you: _____

How did you hear about us? _____

Name of person who referred you: _____ Phone: _____

Question	Y	N	Date & Frequency	Adverse Reactions? <i>Describe symptoms</i>	Stylist Notes
1. Have you ever received eyelash extensions?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Have you had eyelash extensions removed?	<input type="checkbox"/>	<input type="checkbox"/>			
3. Have you used under eye gel patches before?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have you had permanent cosmetics applied to your eye area?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Do you wear daily disposable, extended wear or permanent contacts?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Do you have a tendency to rub your eyes or pull on your eyelashes?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you go tanning (in salon or outside) or get spray tans?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Are you pregnant? If yes, have you discussed having this service with your doctor?	<input type="checkbox"/>	<input type="checkbox"/>	Which trimester? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		

10. Which side do you sleep on?

- Right
 Left
 Back
 Stomach

Please note that you may experience more eyelash extension loss on the side on which you sleep.

11. Do you exercise?
 Yes (If yes, fill out the chart below.)
 No

Type of Activity	Frequency # Times / Week	Indoors or Outdoors?	Stylist Notes
1.			
2.			
3.			
4.			

12. Are you on a special diet?
 Yes*
 No

Please be advised that healthy natural eyelashes and hair growth require a diet rich in amino acids and protein. In addition, low-carb, low-protein and quick-results diets may affect a body's chemical balance, which can lead to loss of or damage to hair/natural eyelashes.

If client is on a special diet recommend Amplifeye® Lash & Brow Fortifier and Amplifeye Lash & Brow Supplement.

13. What brands and products are you currently using around your eyes?

Product Name & Brand	Frequency of Use (Per day / Week / Month)	Stylist Notes
Facial Cleanser:		
Facial Mask:		
Facial Toner:		
Facial Primer:		
Day Moisturizer:		
Night Moisturizer:		
Facial Sunscreen:		
Eye Treatment:		
Eye Primer:		
Eye Cream:		
Eye Serum:		
Eye Makeup Remover:		
Eyeliner:		
Eye Shadow:		
Mascara:		
Eyelash Fortifier/ Conditioner:		
Brow Products		
Hair, Skin and Nail Supplements		

MEDICAL HISTORY:

Questions	Y	N	Type(s)	Date & Frequency	Adverse Reactions? <i>Describe symptoms</i>	Stylist Notes
14. Do you have an allergy to any of the following? If yes, please provide additional information.						
Acrylates or cyanoacrylates? <i>(Example: Topical skin adhesives)</i>	<input type="checkbox"/>	<input type="checkbox"/>				
Nail adhesives?	<input type="checkbox"/>	<input type="checkbox"/>				
Tape (bandages)?	<input type="checkbox"/>	<input type="checkbox"/>				
Long-lasting or waterproof cosmetics?	<input type="checkbox"/>	<input type="checkbox"/>				
Cosmetic, skin care products, topical creams or other topical products or ingredients?	<input type="checkbox"/>	<input type="checkbox"/>				
Any allergies not including those listed above?	<input type="checkbox"/>	<input type="checkbox"/>				
15. Have you had or used any of the following in the last 4 weeks?						
Eye surgery, wounds or infections?	<input type="checkbox"/>	<input type="checkbox"/>				
Exfoliating, skin-tightening or skin-resurfacing facial treatments? (Examples: Acne treatments, chemical peels, microdermabrasion, laser)	<input type="checkbox"/>	<input type="checkbox"/>				
Retin-A, Accutane or similar product?	<input type="checkbox"/>	<input type="checkbox"/>				
History of eye disease, condition, injury or surgery that affected your hair/natural eyelash growth or loss?	<input type="checkbox"/>	<input type="checkbox"/>				

16. How would you describe your hair growth cycle as compared to others? Slow Fast Unsure

17. Please note that **medications** used to treat the following conditions may cause hair/natural eyelash loss. If you are on medications to treat any of the following, please mark them below:

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Allergies (when treated with non-steroidal anti-inflammatory drugs (NSAIDS)) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Autoimmune diseases | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Birth control* | <input type="checkbox"/> Hormone imbalance, hormone therapy* |
| <input type="checkbox"/> Convulsions/ epilepsy | <input type="checkbox"/> Inflammation (when treated with NSAIDS) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Diet/ weight loss | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Dry eye syndrome | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fungus | <input type="checkbox"/> Cancer |

*Although these are not medical conditions, birth control and hormone therapy may result in the thinning or loss of natural eyelashes.

18. List all current medications, herbal supplements and vitamins:

19. Please mark all conditions that apply:

- | | |
|--|---|
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Hormonal disorders or changes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Leamy eye or excessive tearing |
| <input type="checkbox"/> Autoimmune diseases (Crohn's disease, arthritis, lupus, ulcerative colitis, etc.) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Ocular rosacea |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Overactive bladder |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Bronchitis (chronic) | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Sensitive eyes |
| <input type="checkbox"/> Cold sore | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Conjunctivitis (pink eye) | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dry eye syndrome | <input type="checkbox"/> Tendency of redness, rashes or hives |
| <input type="checkbox"/> Eye sties or sores | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heavy eyelid | <input type="checkbox"/> Trichotillomania (hair or eyelash pulling) |
| | <input type="checkbox"/> Other: _____ |

Basic makeup application and normal lifestyle can resume after the eyelash extension application. However, the following activities should be avoided within the first 3 hours: spray or airbrush tanning, exposure to excessive steam, exposure to excessive heat, contact lenses insertion, and non Xtreme Lashes® cosmetics & skincare products

Date	Additional Comments