

# WAXING CONSENT FORM

- HAVE YOU TAKEN ACCUTANE WITH THE PAST YEAR?  YES  NO
- ARE YOU USING RETIN-A, DIFFERIN, OR RENOVA?  YES  NO
- ARE YOU TAKING ANY MEDICATIONS THAT MAKE YOU PHOTOSENSITIVE?  YES  NO
- DO YOU FREQUENT TANNING BEDS?  YES  NO
- ARE YOU CURRENTLY SUNBURN?  YES  NO
- ARE YOU DIABETIC?  YES  NO

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT COULD COMPROMISE YOUR SKIN AND/OR SERVICES BEING OFFERED:

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> ECZEMA/PSORIASIS          | <input type="checkbox"/> HERPES    | <input type="checkbox"/> CANCER         |
| <input type="checkbox"/> COLD SORES/FEVER BLISTERS |                                    |   |

**\*\*PLEASE READ THE FOLLOWING WARNINGS\*\***

IF YOU ARE USING ANY OF THE FOLLOWING MEDICATIONS, YOU CAN NOT BE WAXED TODAY:

- |             |             |                |              |
|-------------|-------------|----------------|--------------|
| - ACCUTANE  | - ADAPALENE | - ISOTRETINOIN | - RETIN-A    |
| - RENOVA    | - ALUSTRA   | - AVITA        | - TAZAROTENE |
| - TRETINOIN | - AVAGE     | - DIFFERIN     |              |

YOU MAY EXPERIENCE SKIN SENSITIVITY/THINNING, WHICH CAN RESULT IN SKIN LIFTING, FROM THE FOLLOWING:

- |                  |               |                                |
|------------------|---------------|--------------------------------|
| - SUNBURNED SKIN | - RETINOL     | - CERTAIN MEDICAL CONDITIONS   |
| - PREGNANCY      | - ANTIBIOTICS | - OTHER MEDICATIONS NOT LISTED |
| - MENSTRUATION   |               |                                |

## CONSENT AND SIGNATURE:

I UNDERSTAND THAT IF I BEGIN USE, OR ARE CURRENTLY USING, ANY OF THE PRODUCTS LISTED IN THE ABOVE WARNING AND DO NOT INFORM THE ESTHETICIAN PRIOR TO CURRENT OR FUTURE TREATMENTS, I ACCEPT FULL RESPONSIBILITY FOR ANY ADVERSE REACTIONS.

I UNDERSTAND THAT WAXING MAY CAUSE SOME REDNESS, BUMPS, SORENESS, AND/OR ITCHING.

## CLIENT CONSENT (OVER 18 YRS OF AGE):

CLIENT SIGNATURE: \_\_\_\_\_

## PARENT/GUARDIAN CONSENT (UNDER 18 YRS OF AGE):

I, \_\_\_\_\_, AUTHORIZE \_\_\_\_\_ WAXING TREATMENT ON \_\_\_\_\_ (A MINOR).

SIGNATURE OF PARENT/GUARDIAN (IF UNDER 18): \_\_\_\_\_

**\*\*IF ANY PROBLEMS OR ISSUES OCCUR POST WAXING, PLEASE CONTACT US IMMEDIATELY!\*\***