



Eyelash Lift and Tint Consent Form

Patch Test & Date:

Full Name:.....

Address:.....

D.O.B:/...../...../

Mobile Number:.....

Email:

GP Name & Address:

Emergency Contact Name & Number:

Medical Questions:

Do you suffer from Eye Infections? Yes / No? If Yes please specify?

.....

Do you suffer with dry eye syndrome? Yes / No? If Yes please specify?

.....

Do you suffer with twitchy or watery eyes? Yes / No? If Yes please specify?

.....

Do you suffer with any skin disorders in the eye area? Yes / No? If Yes please specify?

.....

Have you ever had a reaction to lash glue or tint? Yes / No? If Yes please specify?

.....

Are you Pregnant or breast feeding? Y/N

Do You, or anyone in your household have symptoms of Covid-19? Y/N?

Please do not book or attend your appointment if the answer is Yes.

Please bring Photo Id and proof of age.

Please tick here if you would like to be signed up to our email and receive exclusive offers? Yes / No

I Certify that all the information that I have provided is true and I have answered all the questions above to the best of my knowledge. I am aware that it is my responsibility to inform the therapist of any changes in the information that I have given.

Client Signature:..... **Date:**.....

Therapist Signature:..... **Date:**.....