INDEMNITY FORM / CLIENT CONFIDENTIALLY FORM

Client Name: _____

Salon Name: _____

Please circle: Male / Female

Address: _____

Date of Birth: _____ Phone Number: _____

Email: _____

Previous discomfort, stinging and adverse reactions please tick:

◯	Skin Disorders	◯	Inflammation of the skin	◯	Eye disease
◯	Eye Infections	◯	Recent eye surgery	◯	Blephartitis
◯	Watery eyes	◯	Hayfever	◯	Allergies
◯	Bell's Palsy	◯	Previous reactions to eye treatments	◯	Contact lenses
◯	Allergies to latex/band aids	◯	Allergies to adhesives, glues or bonding agents	◯	Allergies to acetone
◯	Are you pregnant or lactating?	◯	Skin Disorders	◯	Are you taking HRT?

Any medications: _____

Other relevant information: _____

_____

Have you had eyelash or brow tinting, eyelash perming, eyelash extensions or semi permanent mascara applied previously?

Please circle: NO / YES – which treatment?

TINTING ◯ EYELASH PERM/LIFT ◯ EYELASH EXTENSIONS ◯ SEMI PERMANENT MASCARA ◯

Did you experience any reaction to theses treatments?

Please circle: NO / YES – which treatment?

TINTING ◯ EYELASH PERM/LIFT ◯ EYELASH EXTENSIONS ◯ SEMI PERMANENT MASCARA ◯

Please provide details of this reaction:

_____

_____

Did you seek medical advise from a doctor or specialist as a result of this reaction?

Please circle: NO / YES – what was the advise of your doctor/treatment given:

_____

_____

Agreement: I request and consent to these procedures being carried out today without undergoing a sensitivity patch test. The sensitivity test, which if conducted, may indicate my sensitivity / allergy to the products. I understand the contents of this form and take full responsibility for my actions, thus absolving all other parties of their responsibilities, if any, associated with the supply of the products and services(s).

SIGNATURE: _____ DATE: _____

BEAUTY PROFESSIONALS NOTES: _____

TREATMENT BEING PERFORMED: _____