BROW LAMINATION CONSENT AND HISTORY

Name:_____Date_____

Address: _____

Phone: _____ Email:_____

Have you had an eyelash lift or eyebrow lamination in the past? Yes/No If yes, when? _____
Have you had any reactions to eyelash lift or eyebrow lamination products in the past? Yes/No If yes, when? _____
Have you ever used hair color/eyelash tint? Yes/No
Have you ever had an allergic reaction to hair color/eyelash tint? Yes/No
Do you wear contact lenses? Yes/No
Are you currently using eyebrow enhancement serums of any kind? Yes/No
Do you have a history of recurrent eye or tear duct infections? Yes/No
Do you have a history of dry eyes or Sjorgen's Syndrome? Yes/No

List any allergies, illnesses, medical conditions, or medical treatments you have recently used that could interfere with this brow lamination procedure.

_____
_____
_____

Please initial below to certify that you understand each item:

__ Although every precaution will be taken to ensure my safety before, during, and after this brow lamination procedure, I understand that there are risks associated with having brow lamination.
__ I understand that brow lamination is a combination of a perming and conditioning procedure. As with any perming solution, there is a possibility of skin irritation, and I will alert my technician if I should feel any discomfort during the procedure.
__ I understand that, though rare, there is a possibility of irritation, infection, and eye injury if product gets in or near the eyes. Therefore, I agree to keep my eyes closed during the procedure.
__ I agree that if I experience any adverse reaction, that I will contact my technician.
__ I understand that the products used for this procedure may, under rare circumstances, cause irritation that require a physician's follow-up care, even though my technician utilized correct techniques and followed proper safety protocols; if I choose to consult a physician, it will be at my own expense.
__ I understand that the finished shape of my natural brows is unpredictable and will require shaping by my technician to look their best.
__ I understand that the longevity of my results can be affected by both environmental and biological factors, and cannot be guaranteed.
__ I understand that certain activities such as swimming, excessive physical exertion where moisture or sweating is involved may affect the longevity of my results.
__ I understand and agree to follow the pre and post-care instructions provided by my technician for the best results and longevity of my procedure. I accept the consequences resulting from failure to follow these instructions.

Please indicate if the following apply to you currently or in the past:

YES	NO	
☐	☐	Pregnant/Breast Feeding
☐	☐	Skin disease, Irritation, or Trauma in Brow Area
☐	☐	Eye infection
☐	☐	Hypersensitive skin/eyes
☐	☐	Psoriasis/Eczema
☐	☐	Sunburn Date_____
☐	☐	Alopecia
☐	☐	Ultra-Sensitive Skin/Eyes
☐	☐	Blood Thinners
☐	☐	Recent Permanent Makeup Date_____
☐	☐	Herpes Simplex
☐	☐	Scar Tissue in the treatment area.
☐	☐	Pink Eye
☐	☐	Facial Peel or Dermabrasion In Last 2 Weeks
☐	☐	Exfoliation In Last Week
☐	☐	Recent Eye Surgery
☐	☐	Tanning Products
☐	☐	Brow Growth Serums
☐	☐	Taking or Recently Taken Accutane Date_____
☐	☐	Recent Wax In Brow Area Date_____
☐	☐	Reaction To Hair Dye/Perm/Lash Lift Products
☐	☐	Skin disease, Irritation, or Trauma in Brow Area Not Addressed Above

Name: _____

Signature: _____ Date: _____

Aftercare:

To maintain the longevity of your brow lamination treatment, use brow serum supplied by your technician or follow alternative aftercare instructions given.
Avoid getting brows wet for the next 24-48 hours
Do not apply makeup to the brows for 24 hours post-treatment
Do not apply Retin-A, AHA, BHA, or exfoliate the brow area for 72 hours before or after the treatment
No self-tanner products should be used on the face for at least 48 hours post-treatment
Do not use harsh cleansers in the treatment area
Avoid saunas or hot baths for 24-48 hours post treatment

I have read and understood the above information. If I have any concerns, I will address these with my technician. I release my technician from all liability associated with this procedure, which is performed with the utmost attention to safety and proper application using tools and products that the technician has been professionally trained to use.

This agreement will remain in effect for this procedure and all future brow lamination procedures conducted by my technician. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically.
I understand my esthetician/technician will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the esthetician/technician immediately.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the associated risks.

I do not hold the esthetician/technician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure that may be affected by the treatment performed today.

By signing below, I certify that I have read and understand the above statements and agree to them. I also certify that all of the above is true to my recollection and that I have disclosed my medical history as it pertains to this form and the brow lamination procedure.

Name: _____

Signature: _____ Date: _____

Esthetician/Technician: _____ Date: _____

I have been given a 48 hour patch test for this product or have waived this option prior to the start of this procedure. I understand that if a patch test is offered to me and I decline, I cannot hold this technician, establishment, or product distributor/manufacturer responsible for any adverse reaction to this product or procedure under normal or intended application.

Signature: _____ Date: _____

I give permission for my photos to be used as examples for clients and for marketing and promotional purposes.
___Yes ___No ___Yes, but procedure area only, not full face.