SKYLINE Ink Studio

CLIENT PROFILE AND HISTORY

PERSONAL INFORMATION

Today's date _____ Birthdate _____ Age _____

Name _____ Phone _____

Address _____

Email _____ Instagram _____

MEDICAL HISTORY

PLEASE CIRCLE YOUR ANSWER

Y / N History of MRSA
Y / N Chemotherapy/radiation
Y / N Hepatitis ABCD diagnosis
Y / N Cancer (year: _____)
Y / N Easy bleeding
Y / N Abnormal heart condition
Y / N Oily or dry skin (specify: _____)
Y / N Use products retinoids/glycolic acid/alpha hydroxyl
Y / N Used/using Accutane or acne treatment. Date last used:_____
Y / N Tumors/growths/cysts
Y / N Taking blood thinners (aspirin, ibuprofen, etc.)
Y / N Pregnant or breast feeding
Y / N Medication allergies (specify: _____)
Y / N Other allergies (specify: _____)
Y / N Other diseases not listed (specify: _____)

Please list any medications or supplements you are taking: _____

_____

Please list any other known reactions or sensitivities: _____

_____

CLIENT PROFILE AND HISTORY (CONTINUED)

PREVIOUS TREATMENTS AND PROCEDURES

PLEASE CIRCLE YOUR ANSWER

Y	/	N	Botox (specify date: _____)
Y	/	N	Chemical peel (specify date: _____)
Y	/	N	Laser hair removal
Y	/	N	Facelift
Y	/	N	Forehead lift or brow lift
Y	/	N	Brow tint/lash lift/lash tint
Y	/	N	Microblading, microshading, or other eyebrow tattoo
Y	/	N	Permanent eyeliner or eyelid tattoo
Y	/	N	Lip contour/lip blush/lipliner tattoo
Y	/	N	Permanent cheek blush tattoo
Y	/	N	Microneedling or microdermabrasion
Y	/	N	Recent wax, sugaring, threading, or other hair removal

I, _____ agree that this form is true and accurate to the best of my knowledge and that I have disclosed any conditions or history that may put me at risk for reactions to any services received.

Signature: _____ Date signed: _____

Reviewed: _____ Date: _____

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CONSENT AND RELEASE AGREEMENT

REVIEW THE FOLLOWING STATEMENTS AND INITIAL TO VERIFY YOUR UNDERSTANDING

_____ I have been quoted for the cost of today's procedure and informed of the touchup price. I understand that the initial touchup is to be performed within 60 days in order to be booked at the touchup rate. If I book anytime after that, I may be subjected to pay full-price for the service requested.

_____ I understand that anesthetics have varied effectiveness on each person and that discomfort or pain may persist even after a topical anesthetic has been applied.

_____ I understand that some minor swelling, redness, and bruising may occur from this procedure.

_____ I understand that as with any broken skin, there are risks associated with the procedure(s). And that, though rare, there may be complications such as infection, poor color retention, and hyper pigmentation. Proper aftercare practice can help minimize my risk.

_____ I have been provided aftercare instructions, which I will follow to the best of my ability. If any questions or concerns arise, I will notify my cosmetic professional.

_____ I accept the responsibility to decide and explain my desired colors, shapes, and positions for any procedures performed as agreed upon during consultation.

_____ I understand that products containing Retin A, alpha hydroxy, and glycolic acids shall not be used on the treated areas because they may alter the color or cause the pigment to exfoliate prematurely.

_____ I will tell any skincare professionals or medical personnel about my semi-permanent makeup procedure(s), especially if I am to receive an MRI. I understand that this is because the pigment used may contain magnetic minerals.

_____ I understand that exposure to the sun, tanning beds, pools, some skincare products and makeup, sweat, and medications can affect my semi-permanent makeup.

CONSENT AND RELEASE (CONTINUED)

_____ I acknowledge that faces are not symmetrical and adjustments will be made to reduce the appearance of asymmetry.

_____ I have been advised that the pigment is semi-permanent and will fade over time, sometimes unevenly, and understand that touchups will be needed.

_____ I understand that color saturation is not guaranteed and may be negatively affected by hidden scar tissue. I also acknowledge that pigment color may change or fade over time due to circumstances beyond my cosmetic professional's control. I have been informed that some reasons for this include poor healing, improper aftercare, infection, bleeding, and other causes unique to my skin.

_____ I understand that the initial touchup session is meant to correct any fading, unforeseen changes, or uneven appearance.

_____ I understand that infection is rare, but may occur and is serious. I acknowledge that I am to keep the treated areas clean. I will refer to and follow the provided aftercare instructions to be as preventative as possible. I certify that I will contact a medical professional should there be any sign of infection.

_____ I understand that I can have an allergic reaction to products, tools, or materials used. I have been offered a patch test and understand that even if a patch test is performed, it does not guarantee against an allergic reaction. If the patch test is waived, I release my technician from liability if I develop an allergic reaction. I will initial to indicate one: _____ WAIVE the patch test _____ TAKE the patch test

I, _____ certify that I have read and initialed the statements above to verify my understanding and consent. I fully accept the responsibility for the decision to have this work done and give full permission to my hair stylist.

Signature: _____ Date signed: _____

Reviewed: _____ Date: _____

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RISK ACKNOWLEDGEMENT

This document will describe the possibilities and side effects associated with semi-permanent cosmetic tattoos. Please review the following information and sign to verify your understanding.

DISCOMFORT/PAIN: There is associated pain and discomfort that may persist even after topical anesthetic has been applied. Effectiveness of anesthetics and pain tolerance may vary depending on each individual.

INFECTION: Infection is rare, but may occur and is serious. I acknowledge that I am to keep the treated areas clean. I will refer to and follow the provided aftercare instructions to be as preventative as possible.

APPEARANCE: Fading, patchiness, unevenness, and lack of retention may occur. Various factors contribute to these complications such as poor healing, improper aftercare, infection, bleeding, and other causes. Other products and exposures may also alter the final result.

SWELLING/BRUISING: Some individuals may bruise or swell following the procedure.

ASYMMETRY: Faces are not necessarily symmetrical, so while every effort will be made to avoid asymmetry, adjustments may be required during the touchup session to correct any unevenness.

ALLERGIC REACTIONS: Some individuals may have an allergic reaction to numbing agents or pigments used. A patch test may help avoid adverse reactions but cannot guarantee against them. It is the client's responsibility to inform their cosmetic professional of any known allergic reactions or sensitivities.

MRI: Clients are responsible for informing medical professionals about any semi-permanent makeup procedures received, especially if they are to receive an MRI. This is because the pigment used may contain compounds that are magnetic.

Signature: _____ Date signed: _____

Reviewed: _____ Date: _____

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CLIENT CONSULTATION FORM

Name _____ Date _____

This form will indicate your preferences for the shape, thickness, and shade of your eyeliner tattoo. Choose from the following options and sign to confirm that you have fully disclosed your desired style.

EYELINER STYLES

LASH LINE

FLICK

CAT EYE

GLAMOROUS

SELECTED EYELINER STYLE

__Lash Line __Flick __Cat eye

__Glamorous

SHADE

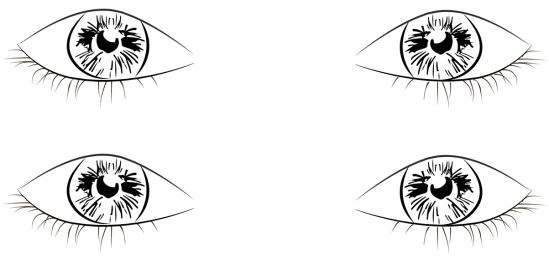
__Light __Medium __Dark __Very dark

THICKNESS

__Thin __Medium __Thick __Very thick

ADDITIONAL COMMENTS

PRACTICE SKETCHES



I, _____

accept the responsibility to decide and explain my desired colors, thickness, and shade for any procedures performed as agreed upon during consultation. I agree that the information on this form is true and accurate.

Signature _____

(SECTION FOR PROFESSIONAL USE ONLY)

Reviewed: _____ Date: _____

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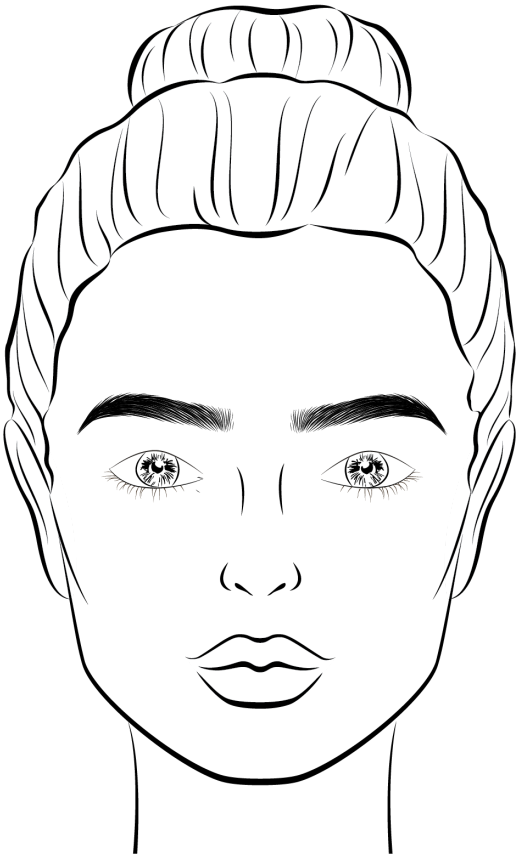
CLIENT TREATMENT CHART

Name _____ Treatment date _____

Touch up date(s) _____

TREATMENT NOTES



Pigment(s) used _____

Blade(s) used _____

Anesthesia used _____

Pain level _____

Bleeding _____

Reactions _____

Pricing _____ Paid _____ Balance _____

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EYELINER TATTOO AFTERCARE

This document will provide the necessary information to care for your new semi-permanent brow tattoo. This information is meant to serve as a guideline and does not guarantee results. Each person's skin responds and heals differently. Healing time, resulting color, retention, touchups required, and scarring will vary depending on each individual.

WHAT TO EXPECT

You may experience discomfort, mild pain/sensitivity, swelling, and redness immediately following the procedure. Your eyes may feel like you have been crying for several hours. These initial symptoms should subside within 1-3 days. Avoid the sun, heavy exercise/ sweating, direct contact, and wetting for the first 10 days after the procedure.

DAYS 1-3: Dry healing results in the best color retention for the eyeliner tattoo area so do not apply any cream or ointment to your eyeliner tattoo. Do not use any eye makeup until all scabs are gone, (including mascara). Do not wear contact lenses for the first 3 days. Sunglasses are recommended to protect your eyes.

DAYS 4-7: Around day 3 or 4, treated areas will begin to scab and flake. DO NOT scratch or remove the scabs. Please note that picking, scratching, or removing healing skin from your tattoo may result in loss of pigmentation and risk infection. They will fall off on their own and any adjustments needed will be corrected during your touch-up.

DAY 10 THROUGH TOUCHUP: You may resume exercise, sun exposure, wetting (showers, facial cleansing, etc.) at your own discretion when your tattoo is done scabbing. They will appear lighter and softer and may darken slightly as the skin regenerates and fully heals. Patchiness or loss of pigment will be addressed and corrected during your touch-up.

CARE INSTRUCTIONS

Do not apply any makeup or products until your eyeliner tattoo is fully healed.

DAYS 1-7: Do not apply makeup or products on around the treated areas. Do not wear contact lenses for the first 3 days. Sunglasses are recommended to protect your eyes and the treated area.

DAYS 8-14: You may resume exercise, sun exposure, makeup, and regular wetting at your own discretion when your tattoo is done scabbing. Continue to avoid chemical peels, exfoliating, and products containing retinal, alpha hydroxy, and glycolic acids until touch-up. Purchasing new eye makeup is recommended to help prevent infection of the treated areas.

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PHOTO AND VIDEO CONSENT

Before and after photos will be taken of your procedure. This document is to request your permission to use these photos for advertising and marketing, portfolios, training, and other use. Your consent is necessary in order to proceed with using said photos.

Please select one of the following options regarding your consent for use of photos from your procedure:

____YES, you may use photos of me and my treated areas

____YES, you may use photos of my treated areas, but please crop them to disguise my face

____NO, you may NOT use photos of me nor my treated areas

Signature: _____ Date signed: _____

Reviewed: _____ Date: _____

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COVID-19 LIABILITY AND RELEASE WAIVER

Name _____ Date _____

The World Health Organization has declared the novel Coronavirus (COVID-19) a global pandemic. The government has set recommendations, guidelines, and prohibitions due to the transmissibility of the virus. Please review and the following and sign this waiver to verify your understanding and agreement to the following disclosures.

_____ I have not experienced symptoms of fever, fatigue, cough, or difficulty breathing or any other symptoms relating to COVID-19 within the last 14 days.

_____ I, as well as all members of my household, have not traveled internationally or visited any area that was reported to be highly affected by COVID-19 within the past 30 days.

_____ I, as well as all members of my household, have not been diagnosed or tested positive for COVID-19 within the last 30 days.

_____ I, as well as all members of my household, have not knowingly been exposed to any individuals who were diagnosed or tested positive for COVID-19 within the last 30 days.

_____ I understand the risks involved and hereby release, waive, and discharge the organization, its board, officers, independent contractors, affiliates, employees, representatives, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.

I, _____ certify that I have read and initialed the statements above to the best of my knowledge. I verify that I have been sufficiently informed of risks associated with COVID-19 and consent to receive services. I fully accept the responsibility for the decision to have this work done.

Signature: _____ Date signed: _____

Reviewed: _____ Date: _____