**LASH & BROW TINTING CONSENT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used hair colour before? Yes/No

Have you ever had an allergic reaction to hair colour? Yes/No

Have you ever had a lash perm before yes/no

Have you ever had an allergic reaction to a lash perm before? Yes/No

Do you wear contact lenses? Yes/No

What over-the-counter or prescription skin care products are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have diabetes, lupus, or any auto-immune disease? Yes/No (If yes, describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any illnesses or conditions you are being treated by a doctor for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking, including over-the-counter herbs, vitamins and supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had your brows or lashes tinted? Yes/No If you had an adverse reaction to a previous tinting, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATCH TEST/WAIVER: (Please circle A or B)

**(A)** I understand that a skin test can determine whether I will suffer a reaction to the products used within 24 hours, but that it is inconclusive whether I will have an allergic reaction at any time in the future. I therefore waiver my option to an allergy test and wish to proceed with treatment.

**(B)** I have undergone or been offered an allergy test prior to my initial treatment and I therefore release the Sister Brows Consultant from any liability related to allergic reactions to the applied pigments or other products used after the procedure, or at a later date.

Sign here:……………………………………………Practitioners signature:…………………………………………..

Although every precaution will be made to ensure your safety and well-being before, during and after your tinting application, please be aware of the possible risks below. Please initial: \_\_\_\_\_ I understand that tinting lashes or brows has some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging or burning, blurry vision and potentially blindness should the tint enter into the eye. \_\_\_\_\_ I understand that if the tinting agent, developer, or mixture of both accidentally comes into contact with my eye, my eye will be flushed with water and medical attention may be required. \_\_\_\_\_ I understand that some irritation, itching or burning may occur to the skin which comes in contact with the tinting agent. \_\_\_\_\_ I understand that there may be some residual dark staining left on the skin following the tinting process of either my lashes, brows or both. This will fade and go away within a short time. \_\_\_\_\_ I understand that, while every attempt will be made to provide me with my chosen colour, everyone’s hair absorbs colour differently and my final results may not be the colour I initially wanted. \_\_\_\_\_ I understand that over the course of several weeks, the tint will gradually lighten and fade. Re-tinting will be required to keep the new colour fresh. Most clients need to re-tint every 3-4 weeks. I have read the above information. If I have any concerns, I will address these with my skin care therapist. I give permission to my therapist to perform the tinting procedure we have discussed, and will hold him/her and his/her staff harmless from any liability that may result from this treatment. 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 practitioner 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 practitioner 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 risks. I do not hold the practitioner, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

Practitioners’ signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT RECORD Name of Client:**

DATE OF TREATMENT:

PRACTITIONERS NAME:

TINT COLOUR USED:

BROW SHAPE (CHANGES ETC):

ADVICE GIVEN TO CLIENT:

NOTES:

DATE OF TREATMENT:

PRACTITIONERS NAME:

TINT COLOUR USED:

BROW SHAPE (CHANGES ETC):

ADVICE GIVEN TO CLIENT:

NOTES:

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DATE OF TREATMENT:

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NOTES:

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**Lash Lift AFTERCARE**

AFTERCARE MUST BE FOLLOWED - AS THIS WILL PROLONG THE LIFE OF YOUR LASH LIFT!!

\*Most importantly do not get your lashes wet in the first 48 hours!

\*Be gentle and respect your new lashes.  Avoid rubbing your eyes and do not play with your lashes in the first 48 hours - please let them set and settle to their desired shape. Resist the temptation to touch

 \*Try to avoid getting them caught on clothes and towels in first 2 days.

\*Do not perm, tint or curl the using a clamp eyelash curlers

\*Avoid wearing mascara in first 48 hours

\*Be careful applying and removing make-up in first 48 hours, do not get the lashes wet.

\*Any eyeliner, eye creams, eye makeup removers, lotions, sun cream or cleansers containing oils - please be careful with during the setting period.

\*Do keep the eye area clean.  This is very important.  Some ladies love their lashes so much they don't even want to clean around them but avoiding proper hygiene can result in an eye infection

\*Try and sleep on your back to avoid crushing your lashes in the pillow.