Client Consent/Health History – Lash Tint/Lift

Name:_____ Date _____

Address:_____ City:_____ State: _____ Zip:_____

Phone: _____ Date of Birth:_____ Occupation:_____

Email Address: _____ How did you hear of us?_____

Would you like to receive my monthly newsletter/Hear about specials and events? ☐ No ☐ Yes

Emergency contact:_____ Phone:_____ Relationship to you:_____

Have you ever had brows/lashes lifted/tinted before? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No

Have you ever had an allergic reaction to hair color? ☐ Yes ☐ No

Do you have diabetes, lupus, any auto-immune disease, or any illness you're being treated by a physician for: _____

_____

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

_____

List any allergies you have: _____

_____

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.

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 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 color, everyone's hair absorbs color differently and my final results may not be the color 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 color fresh. Most clients need to re-tint every 3-4 weeks. _____

I consent to "before and after" photographs for the purpose of monitoring treatment effects, documentation, potential advertising and promotional purposes. _____

I understand that any information provided is to aid the service professional in giving better service and is completely confidential. I understand, have read and completed this questionnaire honestly and truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I agree to keep the service provider updated to any changes in my medical profile and understand that there should be no liability on the service providers part should I fail to do so. I give permission to my skin care specialist to perform treatment we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may

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result from this treatment. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. If I experience any discomfort or pain during the session, I will immediately inform the service professional. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I understand that the services offered are not a substitute for medical care. I also understand that the service provided, and advice of the provider should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a medical professional for any mental or physical ailment I am aware of. I understand the service professional is not qualified to diagnose, prescribe, or treat any skin disease or disorder and nothing said during the course of the appointment be construed as such. 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 skin care specialist responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. By signing below, I hereby authorize Bliss by Sherise to administer treatment services to me, and will hold Bliss by Sherise or its service providers harmless from any liability that may result from this treatment. I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature _____ Date: _____

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