Client
Eyelash and Eyebrow Consultation & Consent Form

Client Name:	**Telephone (Mobile) & Email Address:**
Client Address:	**Date of Birth:**

PROCEDURE CONSENT

I have agreed to have:

(Check and initial all that apply)

- ☐ Eyelash extensions applied and/or removed from my eyelashes
- ☐ Tint applied to my eyebrows and/or my eyelashes and waxing performed on my eyebrows
- ☐ An eyelash lift (perm) and/or eyelash tint applied to my natural eyelashes and/or retouched

Before my technician can perform the procedure/s, I understand I must complete this agreement and provide my consent by signing and dating this five-page consultation and consent form where indicated.

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Your answers to the following General Health and Conditions questions may determine that you are not a suitable candidate for the procedure/s indicated. It is important to answer truthfully for your own Health and Safety as well as that of your technician.

GENERAL HEALTH - Please answer yes or no by placing a tick in the relevant box:

	Yes	No
Any operations, illnesses or injuries in the last 6 months?	☐	☐
Any history of major operations or illnesses?	☐	☐
Any known Disorder or Condition?	☐	☐
Any previous reaction to an eye treatment?	☐	☐

If your answer is Yes to any of the above questions, please provide details:

List any medications taken in the last twelve months (excluding the contraceptive pill, paracetamol and ibuprofen)

Any Allergies - please list:

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CONDITIONS - Please answer yes or no by placing a tick in the relevant box:

Condition	Adverse Reactions	Yes I have the condition	No I do not have the condition
Allergic to adhesives (glues, tapes, band aids, etc.)	Eyelash extensions and Lash Lift use adhesive tapes, glue and gel pads that may cause an allergic reaction		
Chemotherapy Treatments within the last 6 months	Medication for chemotherapy may cause a reaction to the materials used for Eyelash extensions, Lash Lift, and Textured Tint.		
Thyroid Medications	Eyelash extensions will not last due to the medication in the system		
Lasik Surgery less than 4 months (must wait 4 weeks post-op exam for medical consent)	Eyes may have sensitivity to Eyelash Extensions, Lash Lift and products used for prepping the eye area (glues, gel pads).		
Blephoroplasty (must wait 6 months post-op for medical consent)	Eyes may have sensitivity to Eyelash Extensions, Lash Lift and products used for prepping the eye area (glues, gel pads)		
Contact Lenses	Glue used to apply the Eyelash extensions and in the Lash Lift process may get underneath the contact lens and cause corneal abrasion or scratching. **Contact lenses must be removed prior to eyelash extension procedures**		
Extremely oily skin and hair	Natural oils will break-down the adhesives used to bond the Eyelash extensions causing lesser retention than normal		
Pregnancy	If there are any complications such as an allergic reaction the doctor may not be able to prescribe certain medical relief		
Alopecia or Trichotillomania	There may be insufficient hair to perform the procedure and/or due to habitually pulling out hair candidacy may not be appropriate		
Psoriasis or other skin disorders	If the skin is excessively dry, peeling, flaking or tender the procedure may be very uncomfortable and difficult to complete. Reaction risk may be higher		

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I agree to the following:

I understand there are risks associated with:

- Having artificial eyelashes applied to and/or removed from my natural eyelashes
- Having Tint applied to my eyelashes and /or eyebrows and waxing performed on my eyebrows
- Having an eyelash lift (perm) and/or eyelash tint applied to my natural eyelashes and/or retouched

I understand that the eyelash extensions will be applied to the natural lash as determined by the technician so as not to create excessive weight on the natural eyelash thereby preserving the health, growth and natural look of my natural eyelashes.

I understand that eyelash lifts, eyelash and eyebrow tinting and waxing will be performed in accordance with manufacturer's instructions in regards to application and timing.

I understand as part of the procedures eye irritation, eye pain, eye itching, discomfort and in rare cases eye infection or blurriness may occur. I understand and agree that if I experience any of these issues that I will contact my technician and consult a physician at my own expense.

I understand that even though my technician will use the proper techniques, the instruments, tapes, cleansers, eye gel pads, adhesives, removers, tints, waxes, eyelash lift and other products used may irritate my eyes or require further follow-up care.

I understand and agree to follow the aftercare instructions provided by my technician. I realise and accept the consequences of failure to adhere to these instructions that may cause the procedure to not have the expected outcome.

I understand that in order to have the procedure performed I will need to keep my eyes closed for a duration of 30-180 minutes during the procedure. I also understand that I will need to be lying in a reclined position. Any medical conditions that might be aggravated by lying still for a prolonged period of time may mean I will not be able to have the procedure performed on my eyes and/or eyebrows.

This agreement will remain in effect for the procedure and all future procedures conducted by my technician for one year from the date of this signed form. I understand it is my responsibility to advise my technician of any changes in future that may affect my suitability for procedures to be undertaken at any time in the intervening twelve months. I understand that this agreement is binding and that I have read and fully understand all information listed above. I represent that I am over the age of 18 years. If below 18 years of age a parent or guardian must also sign this form.

Client Signature: Date:

Parent or Guardian (if Client is under 18 years of age)
Name and Signature:

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0459 546 556
55 Throsby St, Fairfield Heights,NSW 2165
35D Station St, Bowral NSW 2576

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STILL & MOVING IMAGES RELEASE

I, ______________________________________, give ___________________________________("Service Provider") my unreserved permission for all still and moving images taken or recorded by or on behalf of or made available to my Service Provider, of me, including before and after pictures of my procedure, to be used in one of the areas below:

(Check and initial all that apply)

- ☐ Internally for review and feedback only
- ☐ Used in any or all of the promotional and advertising material of my Service Provider; and/or
- ☐ Provided to any third party, including but not limited to media organisations and my Service Provider's partners, for their use as they see fit.

The images may be used in various media formats including online media, social media, print newspaper, video, public displays, television and electronic means of communication and in any edited form.

I waive any rights and claims, present and future, to any fees or royalties or other benefits whatsoever for or in connection with the use of the Images. If I wish to withdraw permission for Images to be used, I must so inform my Service Provider in writing.

I understand that if I so withdraw permission for the Images to be used, my Service Provider will cease any future new publication or use of the Images, but for several years the Images may appear in printed and electronic material which has already been produced or disseminated.

I understand that my Service Provider will make all reasonable efforts to ensure that any use of the Images by my Service Provider or third parties respects and protects those whose images are recorded; and will manage and use Images owned by my Service Provider appropriately.

I release my Service Provider named above, its employees and agents from any liability (including consequential loss) connected with the publication, reproduction, release or any other of these materials, and for any failure by either my Service Provider or by any third party to comply with the terms of this release.

Client Signature: Date:

Parent or Guardian (if Client is under 18 years of age)
Name and Signature: