CONSENT TO EYELASH LIFT/BROW LAMINATION TREATMENT

Client Name: _____

Salon Name: Spa By Nikki_____ _____

Address: _____City: _____ State: _____ Zip: _____

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Email: _____

Please check if you have previously experienced discomfort, stinging and adverse reactions from any of these:

	Skin Disorders		Inflammation of the skin		Eye Disease
	Eye Infections		Recent Eye Surgery		Blephartitis
	Watery eyes		Hayfever		Allergies
	Bell's Palsy		Previous reactions to eye treatments		Contact Lenses
	Allergies to Latex/Band-Aids		Allergies to adhesives, glues, or bonding agents		Allergies to Acetone
	Are you pregnant or lactating?		Are you taking HRT?		Other (specify below)

Other relevant information: _____

_____

Any medications: _____

Have you had eyelash or brow laminations previously? ◯ **YES** ◯ **NO**

Did you experience any reaction to these treatments? ◯ **YES** ◯ **NO**

Please provide details of the reaction: _____

_____

Did you seek medical advice from a doctor or specialist because of this reaction? ◯ **YES** ◯ **NO**

Agreement: I request and consent to these procedures being carried out today without undergoing a sensitivity patch test. The sensitivity test, which if conducted, may indicate my sensitivity / allergy to the products. I understand the contents of this form and take full responsibility for my actions, thus absolving all other parties of their responsibilities, if any, associated with the supply of the products and services(s).

Client Signature: _____ Date: _____

Service being provided: _____

Esthetician's Notes: _____

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