

LASH EXTENSION CONSULTATION FORM

FULL NAME:

ADDRESS:

CITY:

ZIP CODE:

PHONE:

EMAIL:

**EMERGENCY
CONTACT NAME:**

PHONE NUMBER:

CONSENT SIGNED: YES NO

PREVIOUS LASH EXTENSIONS: YES NO **DATE:** _____

TYPE: CLASSIC HYBRID VOLUME MEGA VOLUME OTHER

COMPLICATIONS: YES NO

EYEWEAR GLASSES: YES NO

CONTACT LENSES: YES NO

HISTORY OF ANAPHYLACTIC SHOCK: YES NO

ALLERGIES: YES NO

WOMAN: PREGNANT OR LACTATING? YES NO

NOTES:

EYELASH EXTENSION CONSENT FORM

I understand that there are risks associated with having artificial eyelashes applied to and/or removed from my natural lashes.

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 the client's natural eyelashes.

I understand that as part of the procedure eye irritation, pain, itching discomfort and in rare cases eye infection may occur.

I understand and agree that if I experience any of these issues with my lashes I will contact my technician and have the eyelash extensions removed immediately and consult a physician at my own expense.

I understand that even though the technician may apply and remove the eyelash extensions properly, that adhesive material may become dislodged during or after the procedure, which may irritate my eyes or require further follow up care.

I understand and agree to follow the aftercare instructions provided by my technician. Failure to follow the aftercare instructions may cause the eyelash extensions to fall out.

I understand that in order to have the eyelash extensions applied to my eyelashes I will need to keep my eyes closed for duration of 60-180 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 that I will not be able to have the procedure performed on my eyes.

This agreement will remain in effect for this procedure and all future procedures conducted by my technician or any other technician conducting business at the salon/spa listed below. I understand that this agreement is binding and that I have read and fully understand all information 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.

I release my technician or salon/spa (_____) from all liability associated with this procedure. There are no guarantees for the bonding time length of the eyelash extensions. My technician and their company is not responsible for any technician errors. I understand that I have been advised to follow the aftercare protocol from my technician so as to avoid any discomfort or adverse side effects after the procedure has been completed.

By signing below, I verify that I have read and understand the above statements and agree to them.

Client Signature:

Date: