INDEMNITY FORM / CLIENT CONFIDENTIALITY FORM

TREATMENT BEING PERFORMED:

Client Name:			-	
			-	
Please circle: Male / Female Address:				
Date of Birth:		· Number:	-	
Email:			_	
Previous discomfort, stinging and adverse reactions please tick:				
Skin Disorders		Inflammation of the skin	0	Eye disease
Eye Infections	0	Recent eye surgery	0	Blephartitis
Watery eyes	0	Hayfever	0	Allergies
Bell's Palsy	0	Previous reactions to eye treatments	0	Contact lenses
Allergies to latex/band aids	0	Allergies to adhesives, glues or bonding agents	0	Allergies to acetone
Are you pregnant or lactating?		Skin Disorders		Are you taking HRT?
Any medications:				
Other relevant information:				
Have you had eyelash or brow tinting, eyelash perming, eyelash extensions or semi permanent mascara applied previously?				
Please circle: NO / YES – which treatment?				
TINTING O EYELASH PERM/LIFT O		EYELASH EXTENSIONS	SEMI PERMANENT MASCARA	
Did you experience any reaction to theses treatments?				
Please circle: NO / YES – which treatment?				
TINTING O EYELASH PERM/LIFT O		EYELASH EXTENSIONS	SEMI PERMANENT MASCARA	
Please provide details of this reaction:				
Did you seek medical advise from a doctor or specialist as a result of this reaction?				
Please circle: NO / YES - what was the advise of your doctor/treatment given:				
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).				
SIGNATURE:		DATE:		_
BEAUTY PROFESSIONALS NOTES:				