

BROW AND LASH DYE TREATMENT CONSENT FORM

FIRST NAME: LAST NAME

DATE OF BIRTH DOCTOR

EMAIL ADDRESS

PHONE NUMBER ()



This product, Liquid Dye with Keratin, is intended for professional use only. It is crucial to read and adhere to the instructions provided, as it contains ingredients that may lead to allergic reactions. Always do a patch test at least 48 hours before the first treatment to test for any allergic reactions.

PLEASE CHECK WHAT APPLIES:

HAVE YOU EVER USED HAIR COLOR BEFORE? yes no

HAVE YOU EVER HAD AN ALLERGIC REACTION TO HAIR COLOR? yes no

HAVE YOU EVER HAD A BLACK TATTOO? yes no

TO MY KNOWLEDGE, I AM NOT ALLERGIC TO COLORANTS LIKE PPD

I REALIZE THAT MY BROW OR LASH PROCEDURE WILL BE TINTING MY BROW HAIR FOR UP TO 6 WEEKS

I REALIZE THAT THE PROCEDURE IS TEMPORARY AND WILL POTENTIALLY BE STAINING MY SKIN FOR UP TO 14 DAYS AND WILL START TO FADE SLOWLY AFTER THE PROCEDURE IS COMPLETE

I UNDERSTAND THAT RESULTS MAY VARY WITH EVERYONE. OVERALL SKIN CONDITIONS AND AFTERCARE WILL ULTIMATELY AFFECT THE RETENTION OF THE BROW AND LASH DYE RESULTS

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I CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND THAT I HAVE READ IT OR IT HAS BEEN READ TO ME. I UNDERSTAND ITS CONTENTS AND I WILL NOT BE DISBURSED A REFUND DUE TO POOR DYE RETENTION.



I HAVE AGREED TO THE FOLLOWING:

- Having tint applied to my lashes or/and brows.
- I understand that in the rare occasions there are risks associated with the procedure such as skin irritation and/or discomfort could occur. I agree that if I experience any of these conditions with my brows and skin that I will contact a professional technician for advice and my GP to seek immediate medical attention.
- I have disclosed all my medical history/allergies.
- I agree to follow the care and maintenance instruction provided to me by my technician, and that if any follow up care is required due to my own mistake or negligence and/or failure to follow these instructions- will be at my own risk.
- I have read and completed this form and have answered to the best of my ability.

AS EVIDENCE OF MY SIGNATURE BELOW, I UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS UPON WHICH SUPERCILIMUM LIQUID DYE WILL BE PERFORMED

PATCH TEST AREA:

DATE:

RESULT:

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SIGNATURE:

