WAXING CONSENT FORM

HAVE YOU TAKEN ACCUTANE WITHIN THE PAST YEAR? ____ YES ____ NO
ARE YOU USING RETIN-A, DIFFERIN, OR RENOVA? ____ YES ____ NO
ARE YOU TAKING ANY MEDICATIONS THAT MAKE YOU PHOTOSENSITIVE? ____ YES ____ NO
DO YOU FREQUENT TANNING BEDS? ____ YES ____ NO
ARE YOU CURRENTLY SUNBURN? ____ YES ____ NO
ARE YOU DIABETIC? ____ YES ____ NO
HAVE YOU EVER BEEN TREATED FOR CANCER? ____ YES ____ NO
IF YES, WHEN AND WHAT TYPE? ____
ARE YOU CURRENTLY TAKING ASPIRIN OR BLOOD THINNERS? ____ YES ____ NO
WHAT IS YOUR CURRENT MENSTRUAL CYCLE DUE DATE? ___________________________
DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT COULD COMPROMISE YOUR SKIN AND/OR SERVICES BEING OFFERED?
____ AIDS/HIV ____ HEPATITIS ____ VERICOSE VEINS ____ ECZEMA/PSORISIS ____ HERPES
____ CANCER ____ COLD SORES/FEVER BLISTERS

****PLEASE READ THE FOLLOWING WARNINGS****

IF YOU ARE USING ANY OF THE FOLLOWING MEDICATIONS, YOU CAN NOT BE WAXED TODAY:

- ACCUTANE	- ADAPALENE	- ISOTRETINOIN	- RETIN-A
- RENOVA	- ALUSTRA	- AVITA	- TAZAROTENE
- TRETINOIN	- AVAGE	- DIFFERIN	

YOU MAY EXPERIENCE SKIN SENSITIVITY/THINNING, WHICH CAN RESULT IN SKIN LIFTING, FROM THE FOLLOWING:

- SUNBURNED SKIN	- RETINOL	- CERTAIN MEDICAL CONDITIONS
- PREGNANCY	- ANTIBIOTICS	- OTHER MEDICATIONS NOT LISTED
- MENSTRUATION		

CONSENT AND SIGNATURE:

I UNDERSTAND THAT IF I BEGIN USE, OR ARE CURRENTLY USING, ANY OF THE PRODUCTS LISTED IN THE ABOVE WARNING AND DO NOT INFORM THE ESTHETICIAN PRIOR TO CURRENT OR FUTURE TREATMENTS, I ACCEPT FULL RESPONSIBILITY FOR ANY ADVERSE REACTIONS.

I UNDERSTAND THAT WAXING MAY CAUSE SOME REDNESS, BUMPS, SORENESS, AND/OR ITCHING.

CLIENT CONSENT (OVER 18 YRS OF AGE):

CLIENT SIGNATURE: ____

PARENT/GUARDIAN CONSENT (UNDER 18 YRS OF AGE):

I, ____________________________________, AUTHORIZE ___________________ WAXING TREATMENT ON

____________________________________ (A MINOR).

SIGNATURE OF PARENT/GUARDIAN (IF UNDER 18): ____

IF ANY PROBLEMS OR ISSUES OCCUR POST WAXING, PLEASE CONTACT US IMMEDIATELY!