

Client Record: Eyebrow/Eyelash Tinting

Please complete this form. This information is critical to your session(s) as it may affect the focus and outcome of it.
All information disclosed will be kept for session purposes only and in strict confidentiality.

Name _____ Date _____ Therapist _____

Personal Skin Health History

Please list any illnesses or conditions you are being treated by a physician for:

Please list any medications you are taking, including over-the-counter herbs, vitamins and supplements:

List any allergies you have:

Have you ever had your brows or lashes tinted? Yes/No

If you had an adverse reaction to a previous tinting, please explain:

Although every precaution will be made to ensure your safety and well-being before, during and after your tinting application, please be aware of the possible risks below.

Please initial:

_____ I understand that some irritation, itching or burning may occur to the skin which comes in contact with the tinting agent.

_____ I understand that if the tinting agent, developer, or mixture of both accidentally comes into contact with my eye, my eye will be flushed with water and medical attention may be required.

_____ I understand that tinting lashes or brows has some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging or burning, blurry vision and potentially blindness should the tint enter into the eye.

_____ I understand that there may be some residual dark staining left on the skin following the tinting process of either my lashes, brows or both. This will fade and go away within a short time.

_____ I understand that, while every attempt will be made to provide me with my chosen color, everyone's hair absorbs color differently and my final results may not be the color I initially wanted.

_____ I understand that over the course of several weeks, the tint will gradually lighten and fade. Re-tinting will be required to keep the new color fresh. Most clients need to re-tint every 3-4 weeks.

____ I understand that I must remove my contacts if I am having my eyelashes tinted.

****If you experience any pain during the session(s), please immediately inform the therapist, so that the work can be adjusted to your level of comfort.**

I am at least 18 years of age or older. I have read the above information. If I have any concerns, I will address these with my skin care therapist. I give permission to my therapist to perform the tinting procedure we have discussed, and will hold him/her and his/her staff harmless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I will not hold the Floating Lotus Therapeutic Spa, or esthetician whose signature appears below, responsible for any potential risks or damages that occur.

Client Signature _____ Date _____

Esthetician Signature _____ Date _____