Soleil
Wellness & Day Spa

Eyelash Tint / Lift Informed Consent

Name:_____Phone: _____ Email:_____

Address:_____City:_____State_____Zip:_____

Have you had an eyelash lift in the past? Yes No If yes, when? _____

Have you ever used hair color/eyelash tint? Yes No

Have you ever had an allergic reaction to hair color/eyelash tint? Yes No

Do you wear contact lenses? Yes No

Are you currently using eye drops of any kind, prescription or over-the-counter? Yes No

Do you have a history of recurrent eye or tear duct infections? Yes No

Do you have a history of dry eyes or Sjorgen's Syndrome? Yes No

List any allergies you have: _____

List any illnesses, medical conditions, or medical treatments you have recently received that would prohibit or compromise the process and retention of this eyelash lift: _____

Although every precaution will be taken to ensure your safety and well-being before, during, and after your eyelash lift, please be aware of the following information and possible risks. ***Please initial****:*

__ I understand that there are risks associated with having an eyelash lift.

__ I understand that as part of the eyelash lift procedure, eye irritation, eye pain, eye itching, discomfort, and in rare cases, eye infection or blurriness could occur.

__ I agree that if I experience any of these conditions with my eyelashes or eyes, that I will contact my technician; if I choose to consult a physician, it will be at my own expense.

__ I understand that the instruments, tapes, cleaners, eye gel pads, adhesives, and/or removers may irritate my eyes or require a physician's follow-up care, even though my technician utilized correct techniques and followed proper safety protocols.

__ I understand that an eyelash lift will lift my natural eyelashes. Depending on my natural eyelash length and strength, results may vary.

__ I understand and agree with the care instructions provided by my technician for the use and care of my eyelashes after the eyelash lift. I realize and accept that the consequences of failure to adhere to these instructions may cause the eyelashes to not stay as lifted as long as originally told.

__ I understand and consent to having my eyes closed and covered for the entire duration of the procedure.

I agree to the following eyelash lift care and maintenance instructions:

In the first 24 hours after the treatment, avoid these things:

- don't wear mascara or any eye makeup
- don't wear contact lenses
- don't get your eyelashes wet
- don't use any products on your lashes
- don't rub your eyes
- don't go swimming
- don't engage in activities that cause excessive sweating
- don't go to saunas
- don't take long showers and try to keep your lashes dry
- don't sleep on your face
- don't use oil-based products

Avoid water contact with the eye area for 24 hours after applications. Water and various products can break the chemical bonds and reverse the effects of your eyelash perm.

This agreement will remain in effect for this procedure and all future procedures conducted by my technician. I have read the above information. If I have concerns, I will address with my esthetician. I give permission to my esthetician to perform the eyelash lifting 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 do not hold the esthetician responsible for any of my conditions that were present, but not disclosed at the time of this procedure that may be affected by the treatment performed today. By signing below, I verify that I have read and understand the above statements and agree to them.

Client Signature _____ _____ Date: _____