High Tide
BEAUTY BAR

LASH LIFT & TINT

Client Intake

GENERAL INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ◯Female ◯Male ◯NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

MEDICAL HISTORY

Please check any of the following medical conditions that apply to you:

- ◯ Conjunctivitis (Pink Eye)
- ◯ Eczema or Psoriasis on the Face
- ◯ Epilepsy
- ◯ Glaucoma
- ◯ Hypersensitivity to light
- ◯ Active Eye Infection or Inflammation
- ◯ Allergic to Glue or Adhesives
- ◯ Keratitis (Inflammation of the Cornea)
- ◯ Recent Eye Surgery
- ◯ Recent Chemotherapy
- ◯ Recent Radiation Therapy
- ◯ Trichotillomania (Compulsive Hair Pulling Disorder
- ◯ Allergic to Lifting Solutions or Tint Dyes
- ◯ Blepharitis (Inflammation of the Eyelids)

If you checked any of the above please give details: _____

_____

Any other conditions: _____

Any known allergies? ◯No ◯Yes _____

List any medications you take regularly, including vitamins, herbal supplements, and aspirin:

_____

Do you wear contacts? ◯No ◯Yes

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I consent to having my eyes closed for the duration of 45–90 minutes, produce ◯No ◯Yes

Are you currently using any of the following?

◯ Retinoids ◯Accutane ◯ Latanoprost (eyelash growth medication)

You agree to the following terms by signing below:

I am over the age of 18 and agree to this agreement and treatment. I have filled out this form truthfully and to the best of my ability. I agree to notify the technician if any of the above information changes. I agree to release my technician from all liability for any injury or damage caused by any misrepresentation.

Client printed Name	*Client signature*	*Date*
Esthetician name	*Esthetician signature*	*Date*

Notes

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Consent + liability

Please initial each statement:

_____ I agree to have a Lash lift and/or eyelash tint applied to and/or retouched on my natural eyelashes. By signing this contract.

_____ I give my technician permission to perform an eyelash perm or eyelash tint on me.

_____ I understand that depending on the sensitivity of my skin during the procedure, some mild but normal symptoms may occur with brow lamination and will resolve within 24 hours. Mild tingling, slight redness from brushing the hairs, and a slight warmth in the area are examples of these symptoms.

_____ I am aware that having an eyelash perm and eyelash tint carries some risk. I also understand that as part of the procedure, eye irritation, pain, itching, discomfort, and, in rare cases, blindness may occur.

_____ I understand that even if my technician perms my lashes correctly, the instruments, tapes, cleaners, eye gel pads, adhesives, and removers used may irritate my eyes/brows or necessitate follow-up care from a physician.

_____ I understand and agree to the care instructions for my permed and/or tinted eyelashes provided by my technician.

_____ I understand and accept that failure to follow these instructions may result in the eyelashes not staying permed for as long as stated.

_____ I agree to the following terms: After Lash Lift: For the next 24 hours, no water should come into contact with the eye area. For the first 24 hours, avoid using mascara, eyeliner, or brow pencil. Avoid using any oil that contains.

You agree to the following terms by signing below:
I am over the age of 18 and agree to this agreement and treatment. I have filled out this form truthfully and to the best of my ability. I agree to notify the technician if any of the above information changes. I agree to release my technician and the employer from all liability for any injury or damage caused by any misrepresentation.

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Client printed Name *Client signature* *Date*

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Patch Test Consent

I, _____, understand that a patch test is required 24-48 hours prior to a lash lift and tint service to ensure that I do not have an allergic reaction to the product being used. I understand that this patch test will be performed on a small section of my lashes and that I must return to the salon within 24-48 hours to have the patch test evaluated.

I understand that if there is any redness, itching, or swelling in the area tested, I will not be able to receive the lash lift and tint service and will need to reschedule for a later date.

I understand that the patch test will be done using the same products and techniques that will be used during the actual lash lift and tint service.

Please initial each statement:

_____ I understand that there are risks associated with tinting and that in some cases, it can cause an allergic reaction.

_____ I confirm that my provider has explained all potential reactions and sensitivities and that I have disclosed all allergies to my provider.

_____ I fully accept responsibility for any risks, reactions, or sensitivities that may occur.

_____ I understand that a reaction could occur at any time, even if I have previously received this treatment.

_____ I understand and agree that if I have any reaction, I will contact my provider right away.

_____ I understand that I may require medical treatment at my own expense. I will not hold my provider liable for any reactions, sensitivities, or injuries that may occur as a result of this.

◯ I consent to have a patch test done ◯ I decline to have a patch test done

I accept this contract and procedures, providing honest and accurate information. I agree to inform the technician of any changes. I also release the technician from liability for any harm due to misrepresentation.

| --- | --- | --- |
| *Client printed Name* | *Client signature* | *Date* |