INDEMNITY FORM / CLIENT CONFIDENTIALLY FORM

PERSONAL DETAILS: Client Name: _____

Salon Name: _____ Please Circle: ◯ Male ◯ Female

Address: _____

_____

Post Code: _____ Date of Birth: _____

Phone: _____ Mobile: _____

Email: _____

PREVIOUS DISCOMFORT, STINGING OR ADVERSE REACTIONS: Please tick any that apply:

◯ Skin Disorders	◯ Inflammation of the skin	◯ Eye Disease
◯ Eye infections	◯ Recent eye surgery	◯ Blephartitis
◯ Watery eyes	◯ Hay Fever	◯ Allergies
◯ Bell's Palsy	◯ Previous reactions to eye treatments	◯ Contact Lenses
◯ Allergies to Latex/band aids	◯ Allergies to glue/bonding agents/adhesives	◯ Allergies to acetone
◯ Are you pregnant/lactating?	◯ Are you on the contraceptive pill?	◯ Are you taking HRT?

Any medications: _____

Other relevant information: _____

Have you had Lash or brow tinting, Lash Lifting, Lash perming, Eyelash extension or semi-permanent mascara applied previously? ◯ Yes ◯ No

Information: _____

AGREEMENT: I request and consent to these procedures being carried out today without undergoing a sensitivity patch test. The sensitivity test, which if conducted may indicate my sensitivity / allergy to the products. I understand the contents of this form and take full responsibility for my actions, thus absolving all other parties of their responsibilities, if any, associated with the supply of the products and services(s).

Signature: _____ Date: _____

BEAUTY PROFESSIONALS NOTES: _____

_____

_____

Treatments being performed: _____

_____