Keratin Lash Lift & LashBotox Treatment Consent Form

First Name:	**Last Name:**	
Phone:	E-mail:	
Address:	**City & Province:**	**Postal Code:**
How did you hear about us? **(if referred by someone please print their name)**	**Occupation:**	
Do you give permission to "company name". to use photographs/videos of you/ your eyes?	**Yes**	**No**
Would you like us to keep you posted about our specials and services?	**Yes**	**No**

PLEASE INITIAL

_____ I agree to have Keratin Lash Lift & LashBotox Treatment for my natural eyelashes. By signing this agreement, I consent to Keratin Lash Lift & LashBotox Treatment by my technician. I understand that it is NOT the responsibility of the technician to diagnose a client's susceptibility to allergies.

_____I DO NOT wish /I DO wish (please mark) to have a Patch Test 48 hours before Keratin Lash Lift & LashBotox Treatment.

_____ I accept full responsibility for determining the treatment outcome (which may include decisions regarding the degree of lash curl, length and colour). I understand that there are many factors that may affect the life of the eyelash lift. There are no guarantees for the length of time the lashes will stay lifted.

_____I understand there are risks associated with having Keratin Lash Lift & LashBotox Treatment. I further understand that as part of the procedure there might be eye irritation, eye pain, eye itching, discomfort, and in rare cases eye infection or blurriness.

_____I agree that if I experience any of these medical conditions with my lashes that I will notify my technician and consult a physician at my own expense.

_____I understand and consent to having my eyes closed and covered for the duration of the 60-120 minutes procedure.

Have you ever tinted your lashes? YES □ (When?_____) NO □

Please be advised that the following ingredients will be used on you during the treatment:

Toluene-2.5 Diamine Sulfate, M-Aminophenol, Castor Oil, Malva Sylvestris, Urtica, Aloe, Soluble Collagen, Hydrolyzed Keratin, Hydrolyzed Silk, Panthenol, Sweet almond oil, Argan oil, Safflower oil, Jojoba oil, Macadamia oil,Tocopherol,Hyaluronic acid.

Consultation Information. Please indicate if you have (or have had) any of the following:

	Yes	No		Yes	No		Yes	No
Allergies			Weak/ brittle lashes			Hives		
Alopecia/ Hair Loss			Dry eye syndrome			Hormone imbalances		
Blepharitis			Eczema			Hypersensitive skin		
Cataracts			Eye infection cyst/stye			Pregnancy/Lactation		
Conjunctivitis			Glaucoma			Menopause		
Contagious disease			Hay fever			Psoriasis		
Recent beauty treatment			Rosacea			Sensitive eyes		
Seizures			Skin or eyelid infection/disorder			Trichotillomania		
Pregnant			Breastfeeding					

If the answer is yes to any of the consultation questions, please provide details_____

_____

I am over 18 years of age and consent to the agreement and to treatment.

Signature:_____ Date:_____