**CLIENT INFORMATION:**

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Appointment: D: \_\_\_\_\_ / \_\_\_\_\_\_/ \_\_\_\_\_\_\_ T: \_\_\_\_\_\_\_\_\_\_ Your Certified Lavish Lashes Specialist is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Is this the first time you have had lash extensions applied?** ! Yes ! No

If no, where have you had them applied? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brand was used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you have worn within the last 60 days any of the following types of lashes**:

| individual | strip | flare | other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you:** Curl | Perm | Tint | No

**Do you wear contacts?**  Yes | No

**Do you habitually rub, pull, or pick your lashes for any reason?**  Yes | No

**Do you have, or are you being treated for any eye illness or injury?** Yes | No

**What side do you predominately sleep on?**

 Right | Left

**Are you able to keep your eyes closed and lie still for up to 2 hours or longer?** Yes | No
**Please check oany of the following that might apply to you**:

\_\_\_\_\_\_\_\_\_ Lasik

\_\_\_\_\_\_\_\_\_ Eye Surgery
\_\_\_\_\_\_\_\_\_ Permanent eye make-up
\_\_\_\_\_\_\_\_\_ Blephroplasty (eye lift)
\_\_\_\_\_\_\_\_\_ Microdermabrasion
\_\_\_\_\_\_\_\_\_ Allergic adhesives/synthetics

\_\_\_\_\_\_\_\_\_ Child birth within last 120 days
\_\_\_\_\_\_\_\_\_ Alopecia
\_\_\_\_\_\_\_\_\_ Thyroid diseases
\_\_\_\_\_\_\_\_\_ Allergic to Glycerin

\_\_\_\_\_\_\_\_\_ Hypersensitivity to cyanoacrylate/ formaldehyde/adhesives/glues

\_\_\_\_\_\_\_\_ Recent Fever/illness

\_\_\_\_\_\_\_\_ Hormonal imbalance or extreme stress

\_\_\_\_\_\_\_\_ Exposure to certain chemicals found in swimming pools, and to bleach, dye and perm hair

\_\_\_\_\_\_\_\_ Eating Disorders
\_\_\_\_\_\_\_\_ Drugs that can causehair loss

\_\_\_\_\_\_\_\_ Chemotherapeutic agents used in cancer treatment

\_\_\_\_\_\_\_\_ Anticoagulants

\_\_\_\_\_\_\_\_ Oral Contraceptives

\_\_\_\_\_\_\_\_ Beta-adrenergic blockers/BP Meds

\_\_\_\_\_\_\_\_ Retinoids/Retinols/Accutane

\_\_\_\_\_\_\_\_ Major Surgery in the last 120 Days

**CONSENT FOR EYELASH PROCEDURE:**

 Although every precaution will be taken to ensure your safety and wellbeing before, during and after your lash extension application, please be aware of the following information and possible risks. Initial Here: \_\_\_\_\_\_\_\_\_\_\_\_

I have agreed to have eyelash extensions applied to and/or removed from my eyelashes. Before my qualified professional can perform this procedure, I understand I must complete this agreement and provide my informed consent by signing and dating where indicated below. *Initial Here:\_\_\_\_\_\_\_\_\_*

For valuable consideration, in order to have my eyelash extensions applied and/or removed from my eyelashes:

1. **Waiver of Liability**. I understand there are risks associated with having artificial eyelashes applied to and/or removed from my existing eyelashes, and that notwithstanding the utmost of care in the application or removal of these products, there still exist risks associated with the procedure and product itself, which include, without limitation, eye irritation, eye pain, discomfort, and in rare cases, blindness if not properly handled. I understand that a certain amount of eyelash adhesive material will be used to attach the artificial Lash Extensions to my existing eyelashes. Even though the Professional may apply or remove my Lash Extensions properly, I understand adhesive material may become dislodged during or after the procedure, which may irritate my eyes or require further follow-up care, at my own expense (after the first 24 hours) to prevent damage to my eyes. I also understand there is more than one technique for applying Lash Extensions to my eyelashes, and I will not attribute any liability to Professional or Jo.Z Beauty and Wellness as a result of this procedure or the use and care of these lashes. I also agree to defend, indemnify and hold harmless Professional and Jo.Z Beauty and Wellness from any and all claims, actions, expenses, damages and liabilities, including reasonable attorneys’ fees which might be asserted against them as a result of my having this procedure performed, or my purchase of these Jo.Z Beauty and Wellness products. As used in this agreement, the terms “Professional” and “Jo.Z Beauty and Wellness” include all of their respective producers, directors, agents, employees, successors and assigns.
2. **Permission to Use Pictures**. I hereby grant to Professional use, Jo.Z Beauty and Wellness the full right to take Photographs of me, my face, my eyes and/or eyelashes, both before and after this procedure, for any advertising, education, or other purposes whatsoever, including the right to retouch these photographs as deemed necessary by Professional or Jo.Z Beauty and Wellness. I further expressly assign any copyright in these photographs to Jo.Z Beauty and Wellness. I also grant my consent for Professional and Jo.Z Beauty and Wellness to use my image and likeness as contained in these photographs for any advertising or other purposes, along with any comments I may provide.
3. **Care and Maintenance**. I agree to follow the care and maintenance instructions provided by Jo.Z Beauty and Wellness and/or Professional for the use and care of my Lash Extensions, and that if any follow up care is required due to my own mistake or negligence, or failure to follow these instructions, this will be at my own expense and risk. I understand that if I do any of the following, it may result in damage to my Lash Extensions or may cause my lashes to fall o" prematurely. Knowing this I agree to follow these tips for best results: I will avoid oil based eye products as these will loosen the bond of my Lash Extensions. I will avoid getting my lashes wet within the first 24 hours after my application. For the first two days after application I understand it is best to avoid swimming, saunas or steam rooms. If I experience any itching or irritation, I agree to contact my Lash Artist Professional immediately to have the lash extensions removed. I agree to avoid using waterproof mascara and to not use an eyelash curler, perm, or tint my Lash Extensions. I agree to not pick, pull or rub my Lash Extensions. I understand that I should not attempt to remove my lash extensions on my own or with any product, but that the procedure requires that my lash extensions be professionally removed.
4. **No Known Medical Conditions / Informed Consent**. I acknowledge that I have been advised of the potential harmful or negative side effects (such as the premature shedding of my eyelash) that the lash extension procedure or removal may cause to those who have specific medical or skin conditions. I understand that the adhesives and adhesive remover are a skin, eye and mucus membrane irritant and that in rare cases persons may be allergic or have hypersensitivity to synthetics, cyanoacrolate or formaldehyde which in small amount may be present in the adhesive. I understand that the procedure requires that I lay still for up to 2 hours or longer with my eyes shut, and that if I wear contacts, I must remove my contact lenses for the duration of the lash extension application or removal. I further state that I have no known medical condition that might be aggravated by the procedure or any medical condition that would prevent me from complying with or heeding to the professional’s or Jo.Z Beauty and Wellness instructions or these warnings.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lash Artist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Below:

 \_\_\_ I understand that a full set of lash extensions can make the appearance of my own lashes about 30-50% thicker, and make my lashes appear 20-50% longer.

\_\_\_ I understand that lash extension services have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in **stinging and burning**, **blurry vision** and **potential blindness** should the adhesive enter the eye or should an allergic reaction occur.

\_\_\_ I understand that some irritation, itching or burning may occur on the skin if the bonding agent comes into contact with it.

\_\_\_ I understand that if the bonding agent comes into contact with my eye, my eye will be flushed with water and I will be assisted in seeking medical attention immediately.

\_\_\_ I understand that this is a semi-permanent procedure, as my natural lashes will continue to grow and fall out normally, making touch-up or “fill” appointments necessary to maintain the original look achieved by replacing the lashes that have fallen out. Most clients require a fill appointment every 2-3 weeks.

\_\_\_ I understand that while every attempt will be made to provide me with the length and fullness I have chosen, my final result may not be what I initially envisioned.

\_\_\_ I understand that it is imperative that I disclose all of the information requested in the Client Profile/Health History.

\_\_\_ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

\_\_\_ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

\_\_\_ I consent to “before and after” photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have any concerns, I will address these with my lash extension specialist. I give permission to my lash extension specialist to perform the lash extension procedure we have discussed, and will hold him/her and his/her staff harmless and nameless 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 lash extension specialist 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 lash extension specialist 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 lash extension specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

If any action is brought to enforce the terms of this Agreement, the prevailing party shall be entitled to its costs and reasonable attorneys’ fees. Any claims arising out of this agreement will be resolved through binding arbitration using the rules of the American Arbitration Association.

This agreement will remain in effect for this procedure, and all future procedures conducted by Professional or any other professional conducting business at the salon/spa establishment listed above.

I agree that this Agreement is binding upon me, and my heirs, legal representatives and assigns. I represent that I am over 18 years of age and that I have the right to enter this agreement, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. By his or her signature below, he or she ratifies and consents to this procedure under these terms.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATCH TEST COMPLETED BY CLIENT DISCLAIMER**

The adhesive used for eyelash extensions is a medical grade and is only applied to lashes, not the skin. It is very unlikely that you will experience an allergic reaction, however it is recommended that a small amount of glue is applied to the skin 1 - 24 hours before a full set of extensions are carried out.

Please complete the following to confirm that a patch test was carried out, and that no

reaction occurred. If there is any sign of redness, itching, swelling or blistering, return to have any traces of adhesive removed and do not proceed with the treatment.

**I have completed a patch test prior to the treatment and noted no reaction to the lash adhesive or the lash remover, therefore I am happy to proceed with the treatment and accept full responsibility for any reaction which might occur.**

**Treatment: Semi-Permanent Individual Eyelash Extensions**

**Client signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**