

# INDEMNITY FORM / CLIENT CONFIDENTIALITY FORM

Client Name: \_\_\_\_\_

Salon Name: \_\_\_\_\_

Please circle: Male / Female

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Previous discomfort, stinging and adverse reactions please tick:

<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Inflammation of the skin	<input type="checkbox"/> Eye disease
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Recent eye surgery	<input type="checkbox"/> Blepharitis
<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Allergies
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Previous reactions to eye treatments	<input type="checkbox"/> Contact lenses
<input type="checkbox"/> Allergies to latex/band aids	<input type="checkbox"/> Allergies to adhesives, glues or bonding agents	<input type="checkbox"/> Allergies to acetone
<input type="checkbox"/> Are you pregnant or lactating?	<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Are you taking HRT?

Any medications: \_\_\_\_\_

Other relevant information: \_\_\_\_\_

Have you had eyelash or brow tinting, eyelash perming, eyelash extensions or semi permanent mascara applied previously?

Please circle: NO / YES - which treatment?

TINTING  EYELASH PERM/LIFT  EYELASH EXTENSIONS  SEMI PERMANENT MASCARA

Did you experience any reaction to these treatments?

Please circle: NO / YES - which treatment?

TINTING  EYELASH PERM/LIFT  EYELASH EXTENSIONS  SEMI PERMANENT MASCARA

Please provide details of this reaction:

\_\_\_\_\_  
 \_\_\_\_\_

Did you seek medical advise from a doctor or specialist as a result of this reaction?

Please circle: NO / YES - what was the advise of your doctor/treatment given:

\_\_\_\_\_  
 \_\_\_\_\_

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: \_\_\_\_\_

TREATMENT BEING PERFORMED: \_\_\_\_\_

