

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Cell Phone: _____ Work: _____

Birthday Month _____ Day _____ Year _____

Emergency contacts name/phone number: _____

Allergies: (latex, bonding agents, acrylates-such as acrylic nails) Y _____ (explain): _____ N _____

Asthma or any respiratory (breathing) problems Y _____ (explain): _____ N _____

Sensitivities (itchy eyes, seasonal hay fever) Y _____ (explain): _____ N _____

Any eye conditions (dry eye, stye, herpes, pink eye) Y _____ (explain): _____ N _____

Medical problems: (such as thyroid, alopecia, hair or lash pulling or picking, Trichotillomania, etc) Y _____ (explain): _____

_____ N _____

Able to lie on your back for 2-3 hours? Y _____ N _____ Are you pregnant or planning to be? Y _____ N _____

Prior eyelash extension procedure? Y _____ N _____ Result? _____

Do you wear lenses? Y _____ N _____ Will you remove them? (It is recommended to remove lenses) Y _____ N _____

Type of eye makeup remover and mascara? _____

Desired length/style of extensions: (natural, longer, dramatic, cat eye, embellished) _____

Sleeping on my face, extreme weather changes, steam, sauna, and other activities may damage the adhesive or crimp the extensions and may require more frequent refills. I reviewed and understand the aftercare instructions and will do my part to help maintain my eyelash extensions. Initial _____

I understand that eyelash extensions require ongoing maintenance (similar to nail rebase) and that Refill fees are based on time and/or the number of extensions that need to be replaced at the Refill appointments. If I wait too long between Refills, I may need to pay for a new full set. If I no longer wish to wear the eyelash extensions, my technician will remove them and I will not try to remove them myself and there may be a fee for removal of the eyelash extensions. Initial _____

I will seek medical care (at my own expense) and contact my eyelash technician immediately if any allergic or adverse reaction occurs. All of my questions were answered and I understand the procedure and risks. Initial _____

I grant permission to use my before and after photos for marketing or examples of my technicians work. Y _____ N _____ (Before and after photos are a permanent part of the technician's records. You may opt out of marketing purposes)

I release my certified Technician, Cindy Karr, from any and all liability associated with this procedure (which will be performed with the utmost attention to safety and proper application using tools and products that the Technician has been trained and certified to use.) This procedure has many variables due to lifestyle, moisture, weather, extreme temperatures, natural eyelash shedding, and other factors. The Technician will assess and decide if I am a candidate for this service to the best of their ability. No guarantees are made or implied. Initial _____

By signing below, I verify that I have read and understand the above statements and agree to them. I also read and initialed the space above.

Client signature: _____ Date: ____/____/____

Technician signature: _____ Date: ____/____/____

Notes: