**Eyelash Lift Consent Form – Consent Form**

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| --- | --- | --- | --- |
| Full Name:Address:Phone: | Date of birth | Gender F [ ]  M [ ]   | Age |
|  **CONDITION** | **ADVERSE CONDITIONS** |
| 1 | YES | NO | Allergic to adhesives? Glue, tapes, band aids, etc. | Eyelash lift uses adhesive tapes, glue, gel pads that my cause an allergic reaction |
| 2 | YES | NO | Chemotherapy treatments within the last 6 months? | Medication for Chemotherapy may cause a reaction to the materials used for eyelash extensions |
| 3 | YES | NO | Have you ever had lash lift done before? How long? |  |
| 4 | YES | NO | Lasik Surgery less than 4 months (must wait 4 weeks post-op exam for medical consent) | Eyes may have sensitivity to eyelash glue and collagen gel pads. |
| 5 | YES | NO | Blepharoplasty must wait 6 months post-op for medical consent | Eyes may have sensitivity to eyelash glue and collagen gel pads. |
| 6 | YES | NO | Have you ever had any permanent cosmetics or tattoos applied? If Yes, specify when and where. | If you have permanent cosmetics or tattoos did you have any problems with healing after they were applied? |
| 7 | YES | NO | Do you bruise easily? | 27 | YES | NO | Are you undergoing radiation or chemotherapy treatment? |
| 8 | YES | NO | Is your skin oily with enlarging pores? | 28 | YES | NO | Are you now, or have you ever been on the acne treatment Accutane? |
| 9 | YES | NO | Do you wear contact lenses? | 29 | YES | NO | Are you wearing a pacemaker? |
| 10 | YES | NO | Are you claustrophobic?  | 30 | YES | NO | Do you take prescription drugs? |
| 11 | YES | NO | Do you have alopecia? | 31 | YES | NO | Are you anemic/have iron deficiency? |
| 12 | YES | NO | Have you ever used Latisse or other lash/brow growth product in the past 3 months? | 32 | YES | NO | Do you have a history of skin sensitivities? |
| 13 | YES | NO | Do you use tobacco? If you use tobacco you may heal slower and this affects the timing on scheduling a touch-up appointment, if applicable. | 33 | YES | NO | Do you have any medical condition that has resulted in a medical professional requiring you to premeditate with an antibiotic prior to a dental or other invasive procedure? |
| 14 | YES | NO | Do you have any heart conditions? | 34 | YES | NO | Do you have allergies to topical makeup? |
| 15 | YES | NO | Are you diabetic? If so, Type 1 or Type 2? | 35 | YES | NO | Do you have dry eyes? |
| 16 | YES | NO | Do you have any autoimmune disorders? | 36 | YES | NO | Do you intentionally tan - direct sun or tanning bed? |
| 17 | YES | NO | Are you sensitive or allergic to skin care cosmetics/ingredients, hand creams or body lotions? | 37 | YES | NO | Do you *personally* have any history of cancer? |
| 18 | YES | NO | Do you have your lips injected with filler materials? | 38 | YES | NO | Do you have a history of stroke or heart attack? |
| 19 | YES | NO | Are you going soon for any plastic surgery or beautifying procedure? What kind? When? | 39 | YES | NO | Do you have problems being anesthetized for a dental procedure? |
| 20 | YES | NO | Do you hyper pigment? (Tendency to develop dark spots on the skin from wounds or sun) | 40 | YES | NO | Do you hypo pigment (lack of pigment on the skin)? |
| 21 | YES | NO | Do you tend to develop keloid or hypertrophy scars? | 41 | YES | NO | Are you allergic to hair dyes or makeup cosmetics? |
| 22 | YES | NO | Do you scar easily from minor skin injures? | 42 | YES | NO | Do you have glaucoma or any other eye disease? |
| 23 | YES | NO | Do you have any seizure related conditions? | 43 | YES | NO | Do you have arthritis? |
| 24 | YES | NO | Do you have a tendency to faint or become dizzy? | 44 | YES | NO | Do you have a high or low blood pressure? |
| 25 | YES | NO | Do you bleed excessively from minor cuts? | 45 | YES | NO | Do you have sinus problems? |
| 26 | YES | NO | Do you have prosthetic implants? | 46 | YES | NO |  |

**I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from procedures received. I am aware that this is my responsibility to inform the technician of my current medical or health conditions and to update this history. The procedures I receive here are voluntary and I release OM SPA LLC and/or technician from liability and assume full responsibility thereof.** I have agreed to have an eyelash lift; I provide my consent by signing

**Please check all contraindications before booking your appointment: https://www.omspachicago.com/pre-after-care \***

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

***I agree to the following:***

I understand there are risks associated with having artificial glue, perm solution that will be applied in this procedure. \_\_\_\_\_\_\_\_(initial)

I understand as part of the procedure eye irritation, eye pain, eye itching, discomfort and in rare cases eye infection may occur. \_\_\_\_\_\_(initial)

I understand that even though the technician may apply and remove the pads and glue properly, the adhesive materials may become dislodged during or after the procedure which may irritate my eyes or require further follow up care. \_\_\_\_\_\_\_(initial)

I understand and agree to the follow after care instructions provided by my technician. Failure to follow the aftercare instructions can cause different results. \_\_\_\_\_\_\_(initial)

I understand that in order to have the eyelash lift I will need to keep my eyes closed for duration of 45 min-50min during the procedure. I also understand that I will need to be lying in a reclined position. Any medical conditions that might be aggravated by lying still for a prolonged period may mean I will not be able to have the procedure performed on my eyes. \_\_\_\_\_\_\_\_\_\_(initial)

This agreement will remain in effect for this procedure and all future procedures conducted by my technician for one year from the date of this signed form. I understand that this agreement is binding and that I have read and fully understand all information listed above. I represent that I am over the age of 18 years. If below 18 years of age a parent or guardian must also sign this form. \_\_\_\_\_\_(initial)

I acknowledge that everything was explained to me, the procedure, the after care and the risks involved. I release, acquits, covenants not to sue and therefore discharges (name of your company), nor providers, estheticians, employees, independent contractors, associates, owners from all Client hereby releases, acquits, covenants not to sue and therefore discharges of and from any and all actions, and knowingly, voluntarily, and expressly waives any claim Client may have against the Released Parties for any injuries or damages (known or unknown), property damage or loss of any kind, including death, whether such injury, damage, loss, or death was caused by the alleged negligence of Provider, another client, or any other person or cause, which Client may sustain as a result of receiving a Lash Lift treatment. \_\_\_\_\_\_\_\_\_\_(initial)

**Terms & Conditions:**

Cancellation and Rescheduling Policy:

To avoid fees/charges please call 48 business hours (2 business days prior your appointment)

There is a full amount charge of the appointment for : No show up or late cancellations, also if you booked a complementary consultation and there is a no show up there will be a $75 charge fee. Client gives consent to OM SPA LLC to charge automatically to the credit card that client has provided on file if terms and conditions haven’t met successfully. \_\_\_\_\_\_\_\_\_\_\_\_\_ (initial)

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

Client (Printed Name) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (If under 18 years of age) Name and Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_