CLIENT INFORMATION FORM

EeVee Sister's Salon

First Name: _____ Last Name: _____

Address: _____

Mobile Phone Number: _____ Date of Birth: _____

Email Address: _____ Best Method of Contact: ☐ Phone Call ☐ Text ☐ Email

How did you hear about me? ☐Website ☐Instagram ☐Facebook ☐Friend/Other _____

Certain conditions may affect lash retention/growth, how frequent a fill appointment may be required and whether or not you are a good candidate for eyelash extensions.

Please check the following conditions that apply to you:

- ☐ Glycerin allergy
- ☐ Latex allergy
- ☐ Allergy or hypersensitivity to formaldehyde, cyanoacrylate or adhesives/glues
- ☐ Use of oral contraceptives
- ☐ Current pregnancy
- ☐ Recent childbirth
- ☐ Hormonal imbalance
- ☐ Recent eye surgery
- ☐ Recent major surgery
- ☐ Use of retinoids (e.g. Accutane or Retin-A)
- ☐ Use of drugs that cause hair loss
- ☐ Chemotherapeutic agents
- ☐ Iron deficiency
- ☐ Permanent eye makeup
- ☐ Dry eyes
- ☐ Sensitive eyes
- ☐ Watery eyes
- ☐ Alopecia
- ☐ Antibiotics
- ☐ Claustrophobia
- ☐ Extreme stress

Any other conditions not listed? _____

Please list any eye medication or drops you are currently using: _____

Are you applying eyelash extensions for daily wear or a special occasion? _____

Is this your first time applying eyelash extensions? ◯ Yes ◯ No

If no, when was your last application? _____

Do you wear glasses or contacts? ◯ Glasses ◯ Contacts ◯ Both ◯ None

What side do you usually sleep on? ◯ Left side ◯ Right side ◯ Back ◯ Stomach

CLIENT WAIVER & CONSENT FORM

Please read and initial the following statements:

_____ I understand the importance of disclosing my health history and other requested details on the Client Information Form and have not withheld any conditions which may affect this procedure.

_____ I understand that synthetic eyelash extensions will be applied to my natural lashes with glue during this service.

_____ I understand that the technician will apply the eyelash extensions to my natural lashes in such a way to prevent any damage and maintain the health of my lashes. As a result, my desired look may not be achieved.

_____ I understand that I am required to lie still with my eyes closed for up to 3 hours or more during the appointment. Opening my eyes prematurely can expose them to the fumes from the adhesive and cause a reaction.

_____ I understand the risks associated with this procedure may include, but are not limited to, itching, redness, irritation, allergic reaction and potential blindness (rare).

_____ I understand that my natural lashes will grow and fall out naturally. In order to replace the fallen lashes and maintain the original look, a fill appointment will be required (usually every 2-3 weeks).

_____ I understand that should an allergic reaction occur, I will contact the technician immediately to arrange for the removal of the extensions. I will also seek medical attention from a physician at my own expense. I understand that no refund for the initial service will be provided.

_____ I will follow the aftercare instructions provided by the technician and not attempt to remove the extensions on my own.

_____ I understand that the adhesive remover used during removal of the extensions may contact my eye and cause a reaction that may require medical attention at my own expense.

_____ I agree to have photographs taken of myself before and after the procedure. I grant permission for my image or likeness to be used for marketing and other purposes including display on social media accounts or a website. I also agree to any image retouching required by the technician. I assign any copyright in the photographs to the technician.

_____ I agree to defend, indemnify and hold harmless the technician below from any and all claims, actions, expenses, liabilities and damages, including reasonable attorney fees, which may be asserted against the technician due to this or future procedures or purchase of any products.

By signing below, I certify that I have read and fully understand the above statements and have had adequate opportunity to have any questions or concerns addressed. I understand the procedure and accept the risks. I understand that this agreement is legally binding. I confirm that I am over the age of 18, of sound mind and fully capable of executing this waiver for myself. (Parental consent will be required if under 18 years old.) This agreement will remain in effect for this procedure and all future procedures provided by the technician below.

Name: _____ Technician: _____

Signature: _____ Signature: _____

Date: _____ Date: _____