

## Crystal's Skin & Beauty

6919 N Dale Mabry Hwy Suite 300

Tampa, Fl. 33614

(813)770-6753

[www.CrystalSkinandBeauty.com](http://www.CrystalSkinandBeauty.com)



## Lash Lift / Tint

### Client Consent Form

---

Date

---

Name (Last, first, middle initial)

How did you hear about us?

---

Street address, City, ST, ZIP Code

---

Primary phone number | Other phone number

Email address

Subscribe to our newsletters/promos?

Yes      No

#### Have you ever had any of the following or adverse reactions to any listed below:

- Skin Disorders
- Eye Infections
- Watery Eyes
- Bell's Palsy
- Allergies to Acetone
- Use of Contraception
- Inflammation of Skin
- Eye Surgery
- Hay Fever
- Contact Lenses
- Pregnant/Lactating
- Allergies to glues, adhesives, bonding agents
- Eye Disease
- Blepharitis
- Allergies
- Allergies to Latex
- Taking HRT
- Previous reactions to eye treatments

If yes to any above, please explain:

---

Current Medications/Supplements:

---

Previously received lash/brow tinting, lash perming, lash extensions or semi-permanent mascara?

- Yes    • No

If yes:

- Tinting    • Lash Perm/Lift    • Lash Extensions    • Semi-Permanent Mascara

Did you experience any reaction to any of these treatments?:

- Yes
- No

If yes, to which service, please explain:

---

Did you seek medical advice from a doctor or specialist as a result of the reaction and if so, what was the advice and/or treatment?:

---

I request & consent to these procedures being carried out today without undergoing a sensitivity patch. The sensitivity test, which if conducted, may indicate my sensitivity or allergy to the products, I agree to contact my treatment provider in the first onset of any reactions that may occur. I understand the contents of this form and have been truthful with all my answers. I 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.

---

Signature

---

Date