Business/Salon: _____

EYELASH EXTENSION CLIENT CONSULTATION, INFORMED CONSENT, LIABILITY RELEASE & PHOTO AUTHORIZATION

Service Provider: _____ **Appointment Date:** _____

Service: Eyelash Extension Application

CLIENT INFORMATION

Full Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:** _____

Phone: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Parent/Guardian (if required): _____ **Relationship:** _____

Please answer every question honestly and explain any 'Yes' response. A 'Yes' answer does not always prevent service, but the provider may delay, modify, or decline the service, follow product-specific precautions, or request medical clearance.

HEALTH & SERVICE SCREENING

Yes / No	Health and Service Screening	Details / Date
Y ☐ N ☐	Current or recent eye/eyelid infection or inflammation (including pink eye, stye, or blepharitis), injury, significant redness, swelling, discharge, pain, or another concern near the service area.	_____
Y ☐ N ☐	Recent eye surgery, procedure, injury, medical treatment, or use of prescription eye medication for which a healthcare professional has limited cosmetic services near the eyes.	_____
Y ☐ N ☐	Known allergy or sensitivity to eyelash extension adhesive, cyanoacrylates/acrylates, latex, medical tape, under-eye pads, cleansers, primers, removers, fragrances, preservatives, or cosmetics.	_____
Y ☐ N ☐	Previous reaction to eyelash extensions, strip-lash glue, adhesive, medical tape, under-eye pads, remover, eye makeup, or another cosmetic product used near the eyes.	_____
Y ☐ N ☐	History of severe allergy or anaphylaxis, asthma, respiratory sensitivity, or sensitivity to adhesive fumes, vapors, fragrances, or strong odors.	_____
Y ☐ N ☐	Chronic dry or watery eyes, frequent eye irritation, glaucoma, blocked tear ducts, recurring blepharitis, or another eye/eyelid condition that could affect comfort or suitability.	_____
Y ☐ N ☐	Contact lenses currently worn, difficulty keeping the eyes fully closed, claustrophobia, inability to recline or remain still, or another concern that may affect safe application.	_____
Y ☐ N ☐	Recent lash lift/perm, tint, extension removal, adhesive exposure, or other eye-area cosmetic service that may have affected the natural lashes or surrounding skin.	_____
Y ☐ N ☐	Natural lashes that are weak, brittle, sparse, shedding, damaged, overprocessed, or otherwise unsuitable for the requested extension length, weight, or style.	_____
Y ☐ N ☐	Alopecia, trichotillomania, unexplained lash loss, chemotherapy or other medical treatment, pregnancy/nursing, or medications/products that may affect skin, eyes, hair growth, sensitivity, or retention.	_____

Additional details, allergies, medications, eye conditions, treatments, previous reactions, or provider instructions:

_____

Business/Salon: _____

EYELASH EXTENSION SERVICE INFORMATION & INFORMED CONSENT

ABOUT THE SERVICE

Eyelash extension application is a cosmetic service in which individual extension fibers or handmade/premade fans are bonded to selected natural eyelashes using professional adhesive. The provider selects the technique, curl, diameter, length, weight, lash map, and number of extensions according to the condition and capacity of the natural lashes, the requested look, and manufacturer instructions. Extensions do not permanently increase the number or thickness of natural lashes. Fullness and appearance change as natural lashes grow and shed, and periodic maintenance is generally needed. Results and retention vary based on natural-lash growth, skin and eye conditions, products, technique, aftercare, cleansing, oils, moisture, heat, rubbing, sleeping habits, medications, lifestyle, and environmental conditions. This form covers eyelash extension application and fill/touch-up application only; removal, lash lift, tint, strip lashes, and other services require separate consultation or consent as applicable.

PRE-SERVICE CONFIRMATION

☐ I reviewed the desired style, curl, length, fullness, and maintenance expectations with the provider, and I understand the provider may adjust the design to protect my natural lashes.

☐ I arrived with reasonably clean lashes and eye area, removed contact lenses when requested, and disclosed recent products, medications, eye conditions, and cosmetic or medical services that may affect the service.

☐ I understand the service may require me to recline with my eyes completely closed and remain as still as reasonably possible for an extended period. I will immediately report burning, sharp pain, significant stinging, breathing difficulty, dizziness, vision changes, or other concerning symptoms.

☐ I understand the provider may postpone, stop, remove or rinse product, shorten or lighten the design, or decline the service if my natural lashes, eye area, disclosures, comfort, or reaction make it unsafe or unsuitable to continue.

POSSIBLE RISKS & RESULTS

Possible risks include temporary or lasting redness, itching, swelling, watering, dryness, burning, irritation, allergic contact dermatitis, sensitivity to adhesive fumes or other products, headache, nausea, respiratory irritation, blepharitis, infection, chemical exposure to the eye, corneal abrasion or other eye injury, temporary visual disturbance, natural-lash breakage or shedding, traction-related hair loss, clumping or lashes adhering together, premature extension loss, uneven appearance, and the need for professional removal or medical evaluation. Severe allergic reactions and serious eye injury are uncommon but possible. Patch or sensitivity testing and careful professional application may reduce some risks but cannot predict or prevent every reaction. Results, fullness, symmetry, comfort, and retention are not guaranteed.

PATCH TEST RECORD

Patch or sensitivity testing, if used, must follow the product manufacturer's instructions and the provider's policy. A negative test does not guarantee that an immediate or delayed reaction will not occur during or after the service.

☐ Patch test completed on _____ at _____. Result: ☐ No observed reaction ☐ Reaction/concern noted

☐ Patch/sensitivity test offered and voluntarily declined by client, when permitted by product instructions and provider policy.

☐ Patch/sensitivity test not required or not performed based on the product manufacturer instructions and provider protocol.

☐ Service postponed; patch testing or medical clearance recommended before proceeding.

CLIENT ACKNOWLEDGMENTS & CONSENT

Initials: _____ I confirm that the information I provided is complete and accurate, and I agree to notify the provider of changes before future services.

Initials: _____ The service, products, expected benefits, reasonable alternatives, limitations, and risks have been explained to me in language I understand. I had the opportunity to ask questions and received satisfactory answers.

Initials: _____ I authorize the provider to select professional products intended for eyelash extension application and to choose the technique, curl, diameter, length, weight, lash map, adhesive, placement, and application method according to manufacturer instructions, my natural lashes, and my consultation.

Initials: _____ I understand that no specific fullness, symmetry, style, comfort, wear time, retention, maintenance interval, or cosmetic result has been promised or guaranteed. Natural lashes grow and shed, extensions require maintenance, and the provider may modify the requested design to protect lash health.

Initials: _____ I agree not to pull, pick, cut, or attempt unsafe removal of the extensions; to follow the written aftercare instructions provided for the products used; and to seek prompt medical care for severe, persistent, or worsening symptoms, breathing difficulty, or any vision change.

Initials: _____ To the fullest extent permitted by applicable law, I voluntarily accept the ordinary and inherent risks described above and release the service provider and business from claims arising solely from those inherent risks. This release does not apply to gross negligence, reckless or intentional misconduct, or liability that cannot lawfully be waived.

Initials: _____ I voluntarily consent to receive the eyelash extension application service described on this form.

Aftercare: Written instructions provided ☐Yes ☐No Client advised that product-specific instructions and the provider's written directions control over generic advice.

Client Printed Name:	_____	**Date:**	_____
Client Signature:	_____	**Time:**	_____
Service Provider:	_____	**Date:**	_____
Guardian Signature:	_____	**Date:**	_____
Guardian Printed Name:	_____	**Relation:**	_____

Business/Salon: _____

OPTIONAL PHOTO/VIDEO AUTHORIZATION & SERVICE RECORD

OPTIONAL PHOTO / VIDEO AUTHORIZATION

Photo and video permission is separate from consent to the eyelash extension service. Declining photo or public-use permission will not affect the client's eligibility for service.

A. Confidential Client Record

☐ I authorize close-up photographs or video of my eyes, eyelids, natural lashes, extensions, and surrounding treatment area for my confidential client record, service planning, lash mapping, quality review, and documentation of results or concerns. These images may not be used publicly unless I also authorize Section B.

☐ I do not authorize photographs or video for my confidential client record.

B. Public, Portfolio, Marketing, or Education Use

☐ I authorize the provider/business to use photographs or video showing only my eyes, eyelids, lashes, and surrounding treatment area, without my name, in portfolios, education, social media, websites, advertising, and printed or digital materials.

☐ I also authorize images or video that show my full face.

☐ Name permission: ☐ No name ☐ First name only ☐ Full name only with separate written approval

☐ I do not authorize any public, portfolio, marketing, advertising, social media, or education use.

I understand that authorized images may be cropped, edited, reproduced, published, and distributed without compensation or further approval. Once content has been publicly shared, the provider may not be able to control copying or re-sharing by others. I may revoke future public use by written notice, but revocation will not require removal of materials already printed, published, or distributed before the notice was received.

Client Initials: _____ **Date:** _____

Parent/Guardian Initials (if required): _____ **Date:** _____

PROFESSIONAL SERVICE RECORD - FOR PROVIDER USE

Service Date: _____ **Provider:** _____

System / Brand: _____ **Client Record #:** _____

Service Performed: ☐ Full Set ☐ Fill/Touch-Up ☐ Partial/Accent **Mfr. Instructions:** ☐ Followed

Product / Step	Product Name / Brand	Lot # / Exp.	Application / Placement Notes	Timing / Conditions
Cleanser / Prep				
Pads / Tape / Barrier				
Primer / Booster				
Adhesive				
Extensions / Fans				
Bonder / Sealer / Other				

Natural Lash Condition: _____ **Eye / Eyelid / Skin Condition:** _____

Desired Style / Lash Map: _____ **Final Result / Notes:** _____

Observations, client response, results, adjustments, isolation concerns, or adverse reaction/action taken:

_____

_____

_____

Aftercare Provided: ☐ Written ☐ Verbal **Recommended Fill / Maintenance Date:** _____

Provider Signature: _____ **Client Post-Service Initials:** _____

TEMPLATE NOTICE FOR THE SERVICE PROVIDER: This sample should be customized for the products and techniques used, manufacturer instructions, licensing rules, insurer requirements, privacy practices, and applicable state/local law. It is general information and is not legal or medical advice. Consider review by a licensed attorney and your professional liability insurer before use.