Business/Salon: _____

LASH LIFT CLIENT CONSULTATION, INFORMED CONSENT & PHOTO RELEASE

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

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 stye, conjunctivitis (pink eye), blepharitis, significant redness, swelling, discharge, open skin, or irritation around the eyes.	_____
Y ☐ N ☐	Severe dry eye, excessive watering, unusual eye sensitivity, uncontrolled eye movement, or difficulty keeping the eyes comfortably closed.	_____
Y ☐ N ☐	Eye injury, surgery, laser procedure, cosmetic/medical eye treatment, or care by an ophthalmologist or other medical provider within the past year.	_____
Y ☐ N ☐	Known allergy or sensitivity to adhesives, tapes, latex, cosmetics, hair-perming/lifting products, thioglycolates, cysteamine, or similar ingredients.	_____
Y ☐ N ☐	Previous reaction, eye injury, lash damage, or unsatisfactory result from a lash lift/perm; or lashes that are weak, brittle, sparse, shedding, damaged, or overprocessed.	_____
Y ☐ N ☐	Lash extensions currently in place, recent extension removal, or adhesive residue on the natural lashes.	_____
Y ☐ N ☐	A lash lift within the past 6-8 weeks, or before the re-service interval recommended for the product system used. Date of last lift: _____	_____
Y ☐ N ☐	Contact lenses, lash-growth serum, prescription eye drops, or other products/medications that may affect the eyes, skin, or lashes.	_____
Y ☐ N ☐	Pregnant, nursing, or experiencing hormonal changes that may affect skin sensitivity, lash condition, or the predictability of results.	_____
Y ☐ N ☐	Any other condition, medication, treatment, allergy, or sensitivity that could affect eye health, skin sensitivity, lash condition, healing, or ability to receive this service safely.	_____

Additional details, allergies, medications, treatments, or provider instructions:

_____

Business/Salon: _____

LASH LIFT SERVICE INFORMATION & INFORMED CONSENT

ABOUT THE SERVICE

A lash lift is a cosmetic chemical service that softens and restructures natural eyelash hair and then sets the lashes over a rod or shield to create a lifted appearance. The service may involve cleansers, adhesives or balms, lifting and setting solutions, tape or under-eye pads, and conditioning products. It does not add lashes, density, thickness, color, or permanent length. Results and longevity vary based on natural lash condition, growth cycle, product system, technique, lifestyle, and aftercare.

PRE-SERVICE CONFIRMATION

☐ I arrived without eye makeup or heavy residue around the eye area, or I authorize the provider to cleanse the area before service.
☐ I have removed my contact lenses and will keep my eyes fully closed and remain as still as reasonably possible throughout the service.
☐ I will immediately tell the provider if I experience burning, sharp pain, significant stinging, breathing difficulty, dizziness, or other concerning symptoms.
☐ I understand the provider may postpone, stop, or modify the service if my lashes, eyes, skin, disclosures, or reaction make it unsafe or unsuitable to continue.

POSSIBLE RISKS & RESULTS

Possible risks include temporary or lasting redness, itching, swelling, watering, dryness, irritation, contact dermatitis, allergic reaction, chemical exposure to the eye or surrounding skin, infection, lash breakage, weakness, frizzing, overprocessing, premature shedding or loss, uneven or undesired curl, underprocessing, or other eye/skin injury that may require first aid or medical evaluation. A patch test and careful professional application reduce some risks but cannot predict or prevent every reaction. Results are not guaranteed, and corrective processing may be unsafe until the lashes have recovered.

PATCH TEST RECORD

Patch testing must follow the product manufacturer instructions and the provider's policy. A negative patch test does not guarantee that a reaction will not occur during or after the service.

☐ Patch test completed on _____ at _____. Result: ☐ No observed reaction ☐ Reaction/concern noted
☐ Patch test offered and voluntarily declined by client.
☐ Patch test 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 an appropriate rod/shield, technique, products, processing times, and other professional adjustments based on my lash condition and the manufacturer instructions.
Initials: _____ I understand that no specific curl, symmetry, duration, or cosmetic result has been promised or guaranteed.
Initials: _____ I agree to follow the written aftercare instructions provided for the specific product system used and to seek prompt medical care for severe, persistent, or worsening symptoms 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 lash lift service described in 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 lash lift service. Declining 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 and lashes for my confidential client record, service planning, 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 and lashes, 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 #:** _____

Product / Step	Product Name	Lot # / Exp.	Application / Notes	Processing Time
Cleanser / Prep				
Adhesive / Balm				
Step 1 - Lifting				
Step 2 - Setting				
Conditioning / Finish				

Rod/Shield Brand: _____ **Size/Type:** _____

Natural Lash Condition: _____ **Lift Goal:** _____

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

_____

_____

_____

Aftercare Provided: ☐ Written ☐ Verbal **Recommended Re-Service 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.