Business/Salon: _____

FACIAL WAXING CLIENT CONSULTATION, INFORMED CONSENT, LIABILITY RELEASE & PHOTO AUTHORIZATION

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

Service: Facial Waxing

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 ☐	Sunburn, windburn, rash, eczema, psoriasis, dermatitis, active acne, cold sore, infection, cuts, abrasions, scabs, bleeding, or other broken, inflamed, or unusually sensitive skin in the treatment area.	_____
Y ☐ N ☐	Current isotretinoin use or isotretinoin taken within the past 6 months (sometimes known by the former brand name Accutane).	_____
Y ☐ N ☐	Use in the treatment area of prescription retinoids or acne medications, retinol, exfoliating acids (AHA/BHA), benzoyl peroxide, topical steroids, scrubs, or other products that may irritate or increase skin fragility.	_____
Y ☐ N ☐	Current antibiotic use, blood-thinning medication, or another medication/supplement that may increase skin sensitivity, bruising, bleeding, photosensitivity, or delayed healing.	_____
Y ☐ N ☐	Recent chemical peel, laser/IPL, microneedling, microdermabrasion, dermaplaning, facial, cosmetic surgery, injectable treatment, radiation, or other professional skin procedure in or near the treatment area.	_____
Y ☐ N ☐	Recent intense sun or tanning-bed exposure, significant tan, spray tan in the treatment area, or planned sun/heat exposure soon after the service.	_____
Y ☐ N ☐	Previous skin lifting/tearing, burn, bruising, allergic reaction, infection, pigment change, scarring, or other adverse reaction from waxing or another hair-removal service.	_____
Y ☐ N ☐	Known allergy or sensitivity to wax, resins/rosin, fragrances, preservatives, dyes, oils, aloe, latex, adhesive products, or pre-wax/post-wax skin products.	_____
Y ☐ N ☐	History of severe allergy/anaphylaxis or a medical condition that may affect skin sensation, circulation, bruising, healing, or infection risk, such as diabetes, immune suppression, or a bleeding disorder.	_____
Y ☐ N ☐	Pregnant, nursing, experiencing hormonal changes, or receiving medical/hormonal treatment that may affect skin sensitivity, facial-hair growth, healing, or expected results.	_____

Additional details, allergies, medications, skin products, recent treatments, previous reactions, or provider instructions:

_____

Business/Salon: _____

FACIAL WAXING SERVICE INFORMATION & INFORMED CONSENT

ABOUT THE SERVICE

Facial waxing is a temporary hair-removal service in which professional soft wax, hard wax, or another wax system is applied to selected areas of the face and removed to pull hair from the follicle. The service may include cleansing, skin preparation, wax application and removal, limited tweezing or trimming to refine the treated area, and post-wax products. It does not permanently remove hair or stop future growth. Results and regrowth vary based on hair length and growth cycle, skin condition, hormones, medications, products, technique, aftercare, sun exposure, heat, friction, and individual response. Some hairs may be too short to remove or may break instead of releasing from the follicle. This form covers facial waxing only; body waxing, threading, sugaring, chemical depilatories, tinting, lamination, lash services, permanent makeup, and other cosmetic services require separate consultation or consent as applicable.

PRE-SERVICE CONFIRMATION

☐ I reviewed the facial area(s), desired shape, and amount of hair removal with the provider, and I understand the provider may adjust or decline the requested service to protect my skin or preserve an appropriate brow shape.

☐ I arrived with the treatment area reasonably clean and disclosed all recent skin-care products, medications, sun/tanning exposure, and cosmetic or medical procedures that may affect the service.

☐ I will remain as still as reasonably possible and immediately tell the provider if I experience excessive heat, burning, sharp pain, significant stinging, dizziness, breathing difficulty, vision changes, or another concerning symptom.

☐ I understand the provider may postpone, stop, cool or remove product, modify the wax type or technique, or decline the service if my skin, disclosures, comfort, or reaction make it unsafe or unsuitable to continue.

POSSIBLE RISKS & RESULTS

Possible risks include temporary or lasting redness, warmth, tenderness, stinging, itching, swelling, bruising, pinpoint bleeding, folliculitis, acne flare, ingrown hairs, broken hairs, incomplete or uneven hair removal, unintended hair removal or shape change, skin lifting/tearing, abrasions, blistering, burns from heated wax, allergic or irritant contact dermatitis, infection, temporary or lasting darkening or lightening of the skin, scarring, and other skin or eye injury that may require first aid or medical evaluation. Severe allergic reactions, significant burns, infection, and permanent scarring are uncommon but possible. Patch testing, temperature checks, proper sanitation, and careful professional technique may reduce some risks but cannot predict or prevent every reaction. Results, comfort, exact shape, complete hair removal, and duration are not guaranteed.

PATCH TEST RECORD

Patch or sensitivity testing, if used or required, must follow the product manufacturer's instructions and the provider's policy. A negative test does not guarantee that a later reaction will not occur and does not rule out skin lifting or injury related to medications, products, recent procedures, or skin condition.

☐ Patch/sensitivity 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 manufacturer instructions and provider protocol.

☐ Service postponed; additional healing time, product discontinuation, 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 facial waxing and to choose the wax type, temperature, preparation, application, removal technique, treated areas, and number of passes according to manufacturer instructions, sanitation practices, my consultation, and the condition of my skin and hair.

Initials: _____ I understand that no exact shape, symmetry, level of hair removal, skin response, duration, or cosmetic result has been promised or guaranteed. Some hair may be too short, may break, or may remain, and regrowth will occur.

Initials: _____ I agree to follow the written aftercare instructions provided for the products and areas treated and to seek prompt medical care for severe, persistent, or worsening symptoms, blistering, signs of infection, 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 facial waxing 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 facial waxing service. Declining photo or public-use permission will not affect the client's eligibility for service.

A. Confidential Client Record

☐ I authorize photographs or video of my face and the selected treatment area(s) for my confidential client record, service planning, before-and-after comparison, 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 the treated facial area(s), without my name, in portfolios, education, social media, websites, advertising, and printed or digital materials.

☐ I also authorize identifiable 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:** _____

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

Area(s) Treated: ☐ Brow ☐ Lip ☐ Chin ☐ Cheek ☐ Sideburn ☐ Other **Protocols:** ☐ Mfr. ☐ Sanitation

Product / Step	Product Name / Brand	Lot # / Exp.	Area / Application Notes	Temp. / Time / Method
Cleanser / Prep				
Oil / Powder / Barrier				
Wax Product - 1				
Wax Product - 2				
Post-Wax Product				
Tweezing / Trimming / Other				

Skin Condition Before Service: _____ **Hair Length / Growth Condition:** _____

Desired Area / Shape: _____ **Final Result / Notes:** _____

Observations, client response, areas treated, results, adjustments, skin lifting, 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.