Business/Salon: _____

EYEBROW LAMINATION CLIENT CONSULTATION, INFORMED CONSENT, LIABILITY RELEASE & PHOTO AUTHORIZATION

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

Service: Eyebrow Lamination

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 ☐	Cuts, abrasions, sunburn, rash, eczema, psoriasis, dermatitis, acne flare, infection, cold sore, or broken/sensitive skin in or near the eyebrow area.	_____
Y ☐ N ☐	Current or recent eye/eyelid infection, inflammation, injury, surgery, significant redness, swelling, discharge, pain, or other medical concern near the service area.	_____
Y ☐ N ☐	Recent eyebrow lamination, lash lift, hair perm/relaxer, bleaching, tinting, waxing, threading, sugaring, dermaplaning, microblading/permanent makeup, peel, laser, or microneedling.	_____
Y ☐ N ☐	Known allergy or sensitivity to brow/lash lamination or perm products, thioglycolates, cysteamine, neutralizers/oxidizers, adhesives, latex, fragrances, preservatives, dyes, or cosmetics.	_____
Y ☐ N ☐	Previous reaction to eyebrow lamination, lash lift, hair perm/relaxer, hair dye/tint, adhesive, or another chemical service or cosmetic product.	_____
Y ☐ N ☐	Use in the treatment area of retinoids, exfoliating acids, acne treatments, prescription creams, topical steroids, or medications/products that may make skin fragile or sensitive.	_____
Y ☐ N ☐	Pregnant, nursing, or experiencing hormonal changes that may affect skin sensitivity, hair condition, or the predictability of results.	_____
Y ☐ N ☐	History of severe allergy or anaphylaxis, asthma/respiratory sensitivity, or another condition that could complicate an allergic or irritation response.	_____
Y ☐ N ☐	Eyebrow hair that is weak, brittle, sparse, shedding, recently bleached, damaged, overprocessed, or otherwise unsuitable for lamination.	_____
Y ☐ N ☐	Alopecia, trichotillomania, unexplained brow-hair loss, or another medical condition affecting the skin, hair, or hair growth in the treatment area.	_____

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

_____

Business/Salon: _____

EYEBROW LAMINATION SERVICE INFORMATION & INFORMED CONSENT

ABOUT THE SERVICE

Eyebrow lamination is a chemical cosmetic service that temporarily restructures and sets natural eyebrow hairs into a more uniform direction and shape. Depending on the product system, the service may involve cleanser, adhesive or styling aid, restructuring/lifting solution, neutralizing/setting solution, and conditioning or finishing products. It does not add new hair, permanently change hair growth, fill sparse areas, or guarantee symmetry or fullness. Results and longevity vary based on natural hair and skin condition, product system, technique, growth cycle, cleansing, oils, sun exposure, swimming, styling, and aftercare. This form covers eyebrow lamination only; tinting, waxing, threading, shaping, permanent makeup, and other add-on services require separate consultation or consent as applicable.

PRE-SERVICE CONFIRMATION

☐ I reviewed the desired brow shape, direction, and finish with the provider, and I understand the provider will select the product system, placement, and processing time based on my natural brow hair, skin, disclosures, and manufacturer instructions.

☐ I arrived with the eyebrow area reasonably clean and disclosed recent products, medications, and cosmetic or medical services that may affect the treatment area.

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

☐ I understand the provider may postpone, stop, rinse/remove product, or modify the service if my skin, hair, disclosures, or reaction make it unsafe or unsuitable to continue.

POSSIBLE RISKS & RESULTS

Possible risks include temporary or lasting redness, itching, swelling, burning, irritation, allergic contact dermatitis, chemical exposure or burn to the skin or eye, infection, dryness, brittleness, overprocessing, frizzing, kinking, uneven direction or shape, unexpected texture or appearance, discoloration, hair breakage, shedding or loss, and other skin or eye injury that may require first aid or medical evaluation. Severe allergic reactions and serious eye injury are uncommon but possible. Patch testing and careful professional application reduce some risks but cannot predict or prevent every reaction. Results are not guaranteed and will gradually change as the brow hairs grow, shed, are cleansed, and are restyled.

PATCH TEST RECORD

Patch testing must follow the product manufacturer's instructions and the provider's policy. A negative patch 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 test offered and voluntarily declined by client, when permitted by product instructions and provider policy.

☐ Patch 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 eyebrow lamination and to choose the product amounts, placement, technique, and processing times according to manufacturer instructions and my consultation.

Initials: _____ I understand that no specific shape, symmetry, fullness, direction, texture, duration, or cosmetic result has been promised or guaranteed; lamination does not add hair or fill sparse areas, and this consent covers eyebrow lamination only.

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 eyebrow lamination 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 eyebrow lamination 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 eyebrows, forehead, eyes, and surrounding treatment area 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 eyebrows 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: Eyebrow Lamination **Mfr. Instructions:** ☐ Followed

Product / Step	Product Name / Brand	Lot # / Exp.	Application / Placement Notes	Processing Time
Cleanser / Prep				
Adhesive / Styling Aid				
Step 1 - Restructuring				
Step 2 - Neutralizing				
Conditioning / Finish				
Other / Removal				

Natural Brow Hair Condition: _____ **Skin Condition:** _____

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

Observations, client response, results, adjustments, 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.