SpaBlue Lash Lifting Form

Date:_____

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City:_____ State: _____

Zip: _____ Cell phone:_____ Home:_____

Work: _____ email: _____

Previous discomfort, burning and adverse reactions:

- Skin Disorders
- ☐ Eye Infections
- ☐ Bell's Palsy
- ☐ Latex Allergies
- ☐ Pregnant or lactating
- ☐ Taking contraceptives

- ☐ Inflammation of the skin
- ☐ Recent Eye Surgery
- ☐ HayFever
- ☐ Previous reaction to eye treatments
- ☐ Allergies to adhesives, glues or bonding agents
- ☐ Are you taking Hormone Replacement Therapy

- ☐ Eye Disease
- ☐ Blepharitis
- ☐ Allergies
- ☐ Contact lenses
- ☐ Allergies to acetone

Please list any medications you are currently taking:

_____
_____
_____
_____

Please list any relevant medical information:

_____
_____
_____
_____

Have you had the following treatments?:

- ☐Tinting ☐Eye Perm | Lift ☐Eyelash Extensions ☐Semi-permanent mascara

Have you experienced a reation to the following treatments?

- ☐Tinting ☐Eye Perm | Lift ☐Eyelash Extensions ☐Semi-permanent mascara

Please provide details about your reaction:

_____
_____
_____
_____

Did you seek medical advice from a doctor or specialist as a result of this reaction?

☐Yes ☐No

If yes, what was the doctors | specialist advise?

_____
_____
_____
_____

AGREEMENT: I request and consent to these procedures being carried out today without undergoing a sensitivity patch test. The sensitivity test, which if conducted, may include my sensitivity | allergy to the products. I understand the contents of this form and take full responsibility for my actions, thus absolving all other parties of their responsibilities, if any, associated with the supply of the products or services and also agree to our terms and conditions.

SIGNATURE: _____ **Date:** _____