CLIENT CONSENT FORM

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your lash lift application, please be aware of the following information and possible risks. Please initial:

_____ I understand that lash lift service may have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in **stinging and burning, blurry vision** and **potential blindness** should the lifting solutions enter the eye or should an allergic reaction occur.

_____ I understand that some irritation, itching or burning may occur on the skin if the lifting solutions come into contact with it.

_____ I understand that if the lifting solutions come into contact with my eye, my eye will be flushed with water and may be required to seek medical attention immediately.

_____ I understand that although the results is shown to last anywhere from 6-8 weeks, it will be different with each individual as not everyone's hair growth and natural hair shedding cycle is the same.

_____ I understand while every attempt will be made to provide me with the lift/curl I have chosen; my final result may not be what I initially envisioned. I understand that my lashes are unique and my results will be different from others.

_____ I understand and agree to the care instructions provided by Enipra Beauty for the use and care of my lifted lashes. I realize and accept the consequences of failure to adhere to these instructions may cause the lashes to not stay lifted as long as told. I understand and agree that NO WATER CAN COME IN CONTACT WITH THE EYE AREA FOR 24 HOURS AFTER APPLICATION.

_____ I agree and consent to having my eyes closed and covered for the duration of the 75-90 minutes procedure.

_____ I understand that it is imperative that I disclose all of the information requested in the Medical History below.

_____ I have cited all conditions and circumstances regarding my health history, medication being taken and any past reactions or allergies.

_____ I understand that I am responsible in notifying my lash lift specialist if I am pregnant. I understand that if I am pregnant, I must be in my second or third trimester and I am required to provide Enipra Beauty with a clearance from my doctor.

_____ I understand that additional conditions could occur to be discovered during the procedure which could affect my ability to tolerate the procedure.

_____ I consent to "before and after" photographs for the purpose of documentation and potential promotional/advertising purposes.

_____ This agreement will remain in effect for this procedure and all future procedures conducted by Enipra Beauty. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to proceed. If I am under 18 years of age, my parent/guardian agrees to the above terms.

I understand that if I have any concerns, I will address these with my lash technician. I give permission to Enipra Beauty and its lash lift specialist, to perform the lash lift procedure we have discussed, and will hold her harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically. I understand Enipra Beauty and my technician will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concern regarding my treatment, I will consult Enipra Beauty immediately. I agree that this constitutes full disclosure, and that it will supersede any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold Enipra Beauty responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (Printed): _____

Client Signature: _____

Allergies/Medication/Medical History:

_____

Date: _____/_____/_____