

Aesthetician _____ Date: _____

TY Sent _____

TSECRET WAXING CONSENT FORM

FIRST NAME _____ LAST NAME _____ M.I. _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS _____

CELL PHONE _____ OTHER PHONE _____

BIRTHDATE (M/D) _____ UNDER 21 21-30 31-40 41-50 OVER 50 SEX M F

HOW DID YOU HEAR ABOUT US? Referred By: _____ Relationship: _____

Internet Search (What did you search for? Ex: "waxing," "best brazilian in orlando") _____

Print Ad/ Articles (Please Specify Publication) _____

Yelp: Facebook: Pandora: YouTube: Other:(Please Specify): _____

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48/72 hours? Y N

Are you using Retin-a, Renova or Accutane (an oral form of Retin-a)? Y N

Are you using any other skin thinning products and/or drugs? Y N

Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon? Y N

Do you use a tanning bed? Y N

Are you a diabetic? Y N

Do you suffer from epilepsy? Y N

Are you currently taking any medications? If so, please list all (including otc drugs/ herbal supplements)

What skin products do you regularly use on your skin?

Have you ever been treated for cancer? If yes, when and what types of therapies were used?

Please list any other illnesses/ conditions you are currently being treated for by a medical professional:

When is your menstrual cycle due? _____

(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is to start and two days after completion.)

Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc.

I have read the above information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my Aesthetician will take every precaution to minimize or eliminate negative reactions as much as possible. Initial _____

I have read and understand the post- treatment client instructions. I am willing to follow the recommendations made by my Aesthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home post treatment care, I will consult the Aesthetician immediately. Initial _____

I agree that this constitutes full disclosure, and that it supersedes 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 risk. I do not hold the Aesthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. Initial _____

SIGNED _____ DATE _____

_____ DATE _____

PARENT/ LEGAL GUARDIAN SIGNATURE

(Minors under the age of 18 must have a parent/legal guardian signature)