WAXING CONSENT FORM

HAVE YOU TAKEN ACCUTANE WITH THE PAST YEAR? ☐ YES ☐ NO

ARE YOU USING RETIN-A, DIFFERIN, OR RENOVA? ☐ YES ☐ NO

ARE YOU TAKING ANY MEDICATIONS THAT MAKE YOU PHOTOSENSITIVE? ☐ YES ☐ NO

DO YOU FREQUENT TANNING BEDS? ☐ YES ☐ NO

ARE YOU CURRENTLY SUNBURN? ☐ YES ☐ NO

ARE YOU DIABETIC? ☐ YES ☐ NO

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT COULD COMPROMISE YOUR SKIN AND/OR SERVICES BEING OFFERED:

☐ AIDS/HIV
☐ ECZEMA/PSORIASIS
☐ COLD SORES/FEVER BLISTERS
☐ HEPATITIS
☐ HERPES
☐ VARICOSE VEINS
☐ CANCER

****PLEASE READ THE FOLLOWING WARNINGS****

IF YOU ARE USING ANY OF THE FOLLOWING MEDICATIONS, YOU CAN NOT BE WAXED TODAY:

- ACCUTANE
- RENOVA
- TRETINOIN
- ADAPALENE
- ALUSTRA
- AVAGE
- ISOTRETINOIN
- AVITA
- DIFFERIN
- RETIN-A
- TAZAROTENE

YOU MAY EXPERIENCE SKIN SENSITIVITY/THINNING, WHICH CAN RESULT IN SKIN LIFTING, FROM THE FOLLOWING:

- SUNBURNED SKIN
- PREGNANCY
- MENSTRUATION
- RETINOL
- ANTIBIOTICS
- CERTAIN MEDICAL CONDITIONS
- OTHER MEDICATIONS NOT LISTED

CONSENT AND SIGNATURE:

I UNDERSTAND THAT IF I BEGIN USE, OR ARE CURRENTLY USING, ANY OF THE PRODUCTS LISTED IN THE ABOVE WARNING AND DO NOT INFORM THE ESTHETICIAN PRIOR TO CURRENT OR FUTURE TREATMENTS, I ACCEPT FULL RESPONSIBILITY FOR ANY ADVERSE REACTIONS.

I UNDERSTAND THAT WAXING MAY CAUSE SOME REDNESS, BUMPS, SORENESS, AND/OR ITCHING.

CLIENT CONSENT (OVER 18 YRS OF AGE):

CLIENT SIGNATURE: _____

PARENT/GUARDIAN CONSENT (UNDER 18 YRS OF AGE):

I, _____, AUTHORIZE _____ WAXING TREATMENT ON _____ (A MINOR).

SIGNATURE OF PARENT/GUARDIAN (IF UNDER 18): _____

****IF ANY PROBLEMS OR ISSUES OCCUR POST WAXING, PLEASE CONTACT US IMMEDIATELY!****