COVID-19 LIABILITY RELEASE

Name _____ Phone _____

☐ I am willing to take a temperature check during my visit to the salon before the services are started.
☐ I understand that I will be asked to come alone unless accompanying a minor.
☐ I understand that I will be asked to wash or sanitize my hands prior to my service starting.

I acknowledge the contagious nature of the COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that the service provider has put in place preventative measures to reduce the spread of the COVID-19.

I further acknowledge that the service provider can not guarantee that I will not become infected with the Covid-19. I understand that the risk of becoming exposed to and/or infected by COVID-19, this may result from the actions, omissions, or negligence of myself and others, including, but not limited to, salon staff, and other salon clients and their families.

I voluntarily seek services provided by the service provider and acknowledge that I am increasing my risk to exposure to COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:
I am not experiencing any symptom of the illness such as

☐ cough	☐ difficulty breathing	☐ fever
☐ chills	☐ repeated shaking with chills	☐ muscle pain
☐ headache,	☐ sore throat	☐ loss of taste or smell.

I have not traveled internationally within the last 14 days.	☐ Yes	☐ No
I have not traveled to a highly impacted area in the last 14 days.	☐ Yes	☐ No
I do not believe I have been exposed to someone with a suspected or confirmed case of COVID-19.	☐ Yes	☐ No
I have not been diagnosed with Covid-19 and not yet cleared as non contagious .	☐ Yes	☐ No
I am following all recommended guidelines and limiting my exposure to COVID-19.	☐ Yes	☐ No

I hereby release and agree to hold the service provider harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the salon, or that may otherwise arise in any way in connection with any services received from the service provider.

I understand that this release discharges the service provider from any liability or claim that I, my heirs, or any personal representatives may have against the salon with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from the service provider. This liability waiver and release extends to the salon together with all owners, partners, and employees.

Date: _____

Signature: _____

PERMANENT MAKEUP

CONSULTATION FORM

Name: _____

Address: _____

Home/Cell Phone:_____ Email address: _____

Emergency Contact
Name / Relationship / Phone: _____/_____/_____

Are you under 18?	☐ YES ☐ NO
Have you had any aspirin or blood thinners in the past week?	☐ YES ☐ NO
Have you ever had any permanent makeup procedures before?	☐ YES ☐ NO
Have you had a chemical peel, laser, forehead / brow lift, or facial fillers ?	☐ YES ☐ NO
If so, last treatment date _____	
Do you have problems healing?	☐ YES ☐ NO
Previous problems with tattoos or has your physician advised you not to have a tattoo at this time?	☐ YES ☐ NO
Are you allergic to any foods, metal, latex, antibiotics, sanitizers? If yes. please list:	☐ YES ☐ NO

Do you presently have or previously had any of the following:

- ◯ Yes ◯ No - History of MRSA
- ◯ Yes ◯ No - Diabetes
- ◯ Yes ◯ No - Hepatitis (A,B,C,D)
- ◯ Yes ◯ No - Easy bleeding
- ◯ Yes ◯ No - Face lift
- ◯ Yes ◯ No - Alcoholism
- ◯ Yes ◯ No - Abnormal Heart Condition
- ◯ Yes ◯ No - Take meds before Dental work
- ◯ Yes ◯ No - Brow or Lash tinting
- ◯ Yes ◯ No - Autoimmune Disorder
- ◯ Yes ◯ No - Oily Skin
- ◯ Yes ◯ No - Cancer year_____
- ◯ Yes ◯ No - Accutane or acne treatment
- ◯ Yes ◯ No - Chemotherapy/ Radiation
- ◯ Yes ◯ No - Tan by booth or sun
- ◯ Yes ◯ No - Tumors/ Growths/ Cysts
- ◯ Yes ◯ No - Difficulty numbing with dental work
- ◯ Yes ◯ No - Taking blood thinnners such as: Aspirin, Ibuprofen, alcohol, Coumadin, ect. _____
- ◯ Yes ◯ No - Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E Acetate, ect. List_____
- ◯ Yes ◯ No - Any diseases or disorders not
- ◯ Yes ◯ No - Do you use skin care products containing Retin-A, glycolic acid or alpha hydroxyl?

FEMALE CLIENTS:

Are you pregnant or trying to become pregnant ? ☐ YES ☐ NO

Are you breastfeeding ? ☐ YES ☐ NO

Are you using oral and / or hormone based contraceptives ? ☐ YES ☐ NO

PLEASE CIRCLE ANY OF THE FOLLOWING THAT MIGHT APPLY TO YOU:

☐ Botox ☐ Fillers ☐ Brow Lift ☐ Face Lift ☐ Easy Bruising ☐ Easy Bleeding ☐ Chemical Peels ☐ Facials

☐ Brow/Lash tint ☐ Brow/Lash lift ☐ Tanning ☐ Spray Tan ☐ Difficulty numbing at Dentist

☐ None of the Above

FOR BROW TATTOOS

Please indicate the desired brow shape

☐ ARCHED ☐ STEEP ARCH ☐ S-SHAPE ☐ ROUNDED ☐ STRAIGHT

FOR EYELINER

Please indicate the desired shape

☐ BASIC ☐ SMOOTH ☐ WINGED ☐ CAT ☐ OTHER

Line thickness

☐ THIN ☐ MEDIUM ☐ THICK

FOR LIP TATTOO

Please indicate the desired style

☐ OUTLINE ☐ BLEND ☐ FULL LIP

DRAWING

BROW & EYELINER

LIPS

PATCH TEST

Name_____Date_____/_____/_____

Patch Testing involves placing small amounts of the substance against the skin and affixing them in place for 48- 72 hours. The testing site is then monitored for local reaction. Potential adverse events include rash at the site, infection, or delayed skin reactions. There is a possibility of an allergic reaction to pigments. Pigment contents are: iron oxide, titanium dioxide, isopropyl alcohol, glycerin, ethanol, and distilled water. A patch test is advisable however it does not ensure a client will not have an allergic reaction.

I CONSENT THE PATCH TEST

I have received a patch test on the date below.

The patch test has been received and it releases the service provider, and assistant(s) from any liability related to any allergies or other reaction to applied tattoo/permanent makeup pigments. I have been informed that reactions can occur at any time in the future. Sun exposure can also cause a reaction with the pigments.

Client:_____ Location:_____

Color:_____

Signature:_____

REACTIONS

NOTES

I WAIVE THE PATCH TEST:

I release the service provider, and assistant(s) from any liability if I develop an allergic reaction to the tattoo/permanent makeup pigments during or after tattoo/permanent makeup procedure(s).

Client:_____

Signature:_____

PERMANENT MAKEUP

CONSENT FORM

Client Name: _____

☐ The nature and method of the proposed permanent makeup (cosmetic tattoo procedure has been explained to me by my technician, including the usual risks inherent in the procedure process, and the possibility of complications during or following its performance.

☐ I understand there may be a certain amount of discomfort or pain associated with the procedure and that other adverse side effects may include minor and temporary bleeding, bruising, redness or other discoloration and swelling. Fading or loss of pigment may occur. Secondary infection in the area of the procedure may occur; however, if properly cared for, is rare.

☐ I understand that a skin test of the pigment is offered upon request, and the test result is not viewed by a medical professional unless I make arrangements to have this done myself. A non-reactive skin test does not preclude an allergic reaction occurring at a future point in time.

I decline the skin test OR I request a skin test. Please initial one of these options.

Client Signature _____ Date_____

☐ I have informed my technician of any existing health problems.

☐ I acknowledge that complications are always possible as a result of the permanent makeup procedure, particularly in the event, my post-procedural instructions are not followed.

☐ I acknowledge that hyper-pigmentation (Darkening of the skin) or hypo-pigmentation, (The absence of color in the skin), or scarring is a possibility as a result of my body's reaction to the skin being broken during the procedure. I realize that my body is unique, and my technician cannot predict how my skin may react as a result of this procedure.

☐ I acknowledge the receipt of written instructions advising me of the proper care of my procedures, and I recognize the absolute necessity for following these instructions.

☐ I acknowledge that the procedure will result in a permanent change to my appearance and that no representations have been made to me as to the ability to later change or remove the results.

☐ I understand that future laser treatments or other skin altering procedures, such as plastic surgery, implants and injections may alter and degrade my Permanent Makeup. I further understand that such changes are not the responsibility of my technician.

☐ I further understand that such changes in my appearance may not be correctable through further permanent makeup procedures.

☐ I am aware that cosmetic tattooing is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedure.

☐ I authorize my technician to obtain pre-procedural and post-procedural photographs and give her permission to use such photographs for publication and/or for teaching purposes, as she chooses.

☐ I understand that tattoos may cause MRI (Magnetic Resonance Imaging) artifacts and that there may be a warming and/or tingling sensation in the permanent cosmetic procedural area during the MRI due to the iron oxide properties of some pigments. It is understood that I should advise my physician that I do have permanent cosmetics (a tattoo) in the event an MRI procedure is prescribed.

☐ The fee for permanent makeup services has been explained to me and has been agreed upon. I understand the total fee for services rendered is due upon completion of the initial procedure(s) and that there will be separate fees

for any future modification of the design(s) or major color change(s).

☐ Due to the fact that your approval is obtained prior to the final selection of color to be implanted and design application(s) to be applied, we have a no refund policy.

☐ For some skin types, permanent makeup may be a multi-session process. In addition to your initial application, you are entitled to a post-evaluation appointment. At the post-evaluation appointment, I will determine if a touch-up to the initial application is required. You must schedule your post evaluation appointment within 45 days after the initial procedure.

☐ It has been explained to me that immediately after the procedure(s) is completed, the color will appear darker than when the procedure heals. It has also been explained that within a short period of time, during the healing process, the color will lighten.

☐ I understand that if needed, a complimentary touch up will be provided if done within 30 days of the initial appointment. If the touch up is done after the 30 days, an additional charge applies.

☐ The salon does not guarantee the success of removal and or corrective procedures due to the large number of variables that affect the success of such procedures. Client acknowledges counsel by the technician as to the probability of success of such procedures.

☐ I agree that my technician and the employer is limited to the cost of the procedure performed unless it is proven that the technician was negligent in the performance of her duties. In the event of disputes that cannot be amicably resolved, the technician, the employer and client agree to binding arbitration to resolve disputes.

☐ I have read and understood the contents of each paragraph above. I have received no unrealistic warranties or guarantees with respect to the benefits to be realized from, or consequences of, the aforementioned procedure(s).

☐ I acknowledge by signing this consent form, have been given the full opportunity to ask any and all questions about permanent makeup procedure(s) and process(es) from my technician.

Client:_____ Date:_____
(First Visit Signature) (First Visit Date)

Client:_____ Date:_____
(Second Visit Signature) (Second Visit Date)

I personally reviewed the above information with my client or the client's representative.
Permanent Makeup Technician _____ Date:_____
(First Visit Signature) (First Visit Date)
Permanent Makeup Technician _____ Date:_____
(Second Visit Signature) (Second Visit Date)

PHOTOGRAPH & VIDEO RELEASE FORM

I hereby grant permission to the rights of my image, likeness, and sound of my voice as recorded on audio or video without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- educational presentations or courses
- informational presentations
- online educational courses
- educational videos
- promotional materials

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release, nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio, or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Street Address/P.O. Box_____ City _____
Prov/Postal Code/Zip Code_____ Phone _____
Email Address_____

Signature_____ Date_____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____