**Elle Skin Therapy & Waxing**

**Waxing Consent**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Home #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to be notified via mail/email about future promotions and news? \_\_ No \_\_ Yes

Have you ever been waxed before? **\_**\_ No \_\_ Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During or after waxing have you ever experienced any of the following?

Severe redness Blistering Skin lifting/peeling Breakouts

Are you taking or using any of the following medications/products?

Hormone Replacement Therapy Accutane Retin-A Adapalene Renova

Antibiotics Hydrocortisone Heart medications Differin Gel Glycolic acid

Lactic acid Exfoliating scrubs Alpha Hydroxy acid (AHA)

Others that may make you sensitive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any health problems I may need to know about? **\_**\_ No \_\_ Yes, please list

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Have you had excessive sun exposure in the last 48 hours? **\_**\_ No \_\_ Yes

Are you currently undergoing any of the following procedures?

Chemical peels Laser treatments Facial surgery Dermabrasion

WOMEN ONLY: Are you pregnant? \_\_ No \_\_ Yes

Are you having or due for your menstrual cycle? \_\_ No \_\_ Yes

**\*Anyone showing signs of redness, rash, open and/or abraded skin, an active lesion of Herpes Simplex I or II, sunburn (either from natural sun exposure or a tanning bed), psoriasis or eczema (in the area to be waxed) cannot receive waxing services.**

**\*I confirm to the best of my knowledge that the answers I have given are correct and I have not withheld any information that may be relevant to my treatment.**

**\*New use of any of the medications listed above increases the possibility of a reaction. Please inform the Esthetician if you have begun taking any new medications since your last session and/or any future changes involving the skin.**

**\*Please note waxing can have certain side effects such as skin removal, redness, scabbing, bruising, scarring, swelling, tenderness, hyperpigmentation, and/or pimples.**

I have read the above information, and if I had any concerns, I have addressed them with my esthetician. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her 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 using. I understand my esthetician will take every precaution to minimize negative reactions.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Esthetician signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_