



**UNLIMITED
POTENTIAL**
A SKINCARE STUDIO

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Eyelash Extension Form

Name _____

Address _____

Email _____

Phone _____

Date of Birth _____

Do you have allergies to adhesives (glues, tapes, band aids)? **YES NO**

Have you received chemotherapy within the past 6 months? **YES NO**

Are you taking medication for a thyroid disorder? **YES NO**

Do you wear contact lenses? **YES NO**

Is your hair and skin extremely oily? **YES NO**

I understand that in order to have eyelash extensions applied to my lashes, I will need to keep my eyes closed for the duration of 1-2 hours during the procedure. I also understand that I will need to be lying in a reclined position.

I understand that thyroid condition(s) may decrease the duration of the eyelash adhesive.

I understand as part of the procedure eye irritation, eye pain, eye itching, discomfort and in rare cases eye infection may occur.

I understand and agree that if I experience any of the above issues with my lashes that I will contact my lash extensionist and have the eyelashes removed immediately and consult a physician at my own expense.

I understand that adhesive materials may become dislodged during or after the procedure, which may irritate my eyes or require further follow up care.

I understand and agree to follow the aftercare instructions provided by my eyelash extensionist. Failure in aftercare may decrease the duration of the eyelash extensions.

Client Signature _____ Date _____