

# WAXING CONSENT FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ DOB: \_\_\_\_\_

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48-72 hours?  Yes  No

Are you using Retin-a, Renova, or Accutane?  Yes  No

Are you using any other skin thinning products and/or drugs?  Yes  No

Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon?  Yes  No

Do you use a tanning bed?  Yes  No

Are you diabetic?  Yes  No

Have you ever been treated for cancer?  Yes  No

Are you menstruating or about to begin menstruating?  Yes  No

List any medications you are currently taking:

List any skin products you regularly use:

List any other illnesses or conditions you are currently being treated for:

**PROCEDURE.** Procedure Waxing is a procedure to remove unwanted hair from its roots. Hot wax is applied to the skin and then quickly pulled away, taking hairs with it.

**SIDE EFFECTS.** Waxing may cause side effects. The side effects listed here are merely examples and are not intended to be an exhaustive list. Every person is different, and there is no guarantee that you will not experience more severe side

effects. The most common side effects include quickly dissipating, mild discomfort when the wax removes hair from its root. Waxing may cause inflammation, welts, hives, skin lifting, and reddening or small breakouts. This is usually not severe and typically will subside within a few days. Please contact us immediately if you experience more severe or long-lasting side effects.

**WAIVER.** I understand and acknowledge that there are risks involved with the waxing procedure(s), including, but not limited to, those side effects listed above. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby waive \_\_\_\_\_ of liability if such results or complications occur. I further understand that my failure to follow post-procedure instructions may also lead to undesired results, complications, or effects and hereby waive \_\_\_\_\_ of liability if such results or complications occur. In consideration for \_\_\_\_\_ performing this procedure(s), I agree that I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure(s) or side effects I may experience after the procedure(s) is performed. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against \_\_\_\_\_, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of the procedure(s).

**I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to, and authorize \_\_\_\_\_ to perform, the procedure(s) described above on me.**

**Client's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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