



MICROBLADING

Consultation Form

Client Information:

Name: _____ Date of birth: _____ ☐ Female ☐ Male ☐ Other

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? _____

Would you like to be added to our email list for specials and discounts? ☐ Yes ☐ No

Medical History:

Please check any of the following conditions.

- | | | |
|--|--|---|
| ☐ Hair Loss | ☐ HIV | ☐ Healing Problems |
| ☐ Trichotillomania | ☐ Alopecia | ☐ Prolonged Bleeding |
| ☐ Hemophila | ☐ Cancer | ☐ Low Blood Pressure |
| ☐ Liver Disease | ☐ Sensitivity to cosmetics | ☐ Circulatory Problems |
| ☐ Thyroid disturbances | ☐ Artificial Heart Valve | ☐ Botox/filler injections |
| ☐ Anemia | ☐ Fainting spells or dizziness | ☐ Diabetes |
| ☐ Epilepsy | ☐ Tumors, growths, cysts | ☐ High Blood Pressure |

Are you currently Pregnant or currently nursing? ☐ Yes ☐ No

Have you received chemotherapy or radiation in the past year? ☐ Yes ☐ No

Are you currently on blood thinners or medications that increase bleeding time. ☐ Yes ☐ No

Do you have any freckles, moles, or sunburn in the procedure area? ☐ Yes ☐ No

Do you have any skin conditions (acne, keloid scarring, eczema, psoriasis) or other skin sensitivities? ☐ Yes ☐ No

Allergies:

Please check any of the following allergies.

- | | | |
|---------------------------------|----------------------------------|--------------------------------|
| ☐ Latex | ☐ Prilocaine | ☐ Lanolin |
| ☐ Lidocaine | ☐ Medication | ☐ Glycerin |
| ☐ Vaseline | ☐ Paints | ☐ Metals |

Any other conditions: _____

List any medications you take regularly including vitamins, herbal supplements, aspirin:



MICROBLADING

Consent + Liability

_____ I agree to have Microblading applied to my natural eyebrows. By signing this agreement, I consent to the procedure of Microblading by my technician.

_____ I understand that I might have an allergic reaction to the pigment or anesthetic cream used in the procedure and I accept the risk that such a reaction is possible.

_____ I understand that infection is always possible as a result of the procedure, particularly in the event that I do not take proper care of the area following the procedure.

_____ I agree that if I experience any of these medical conditions with my eyebrows that I will contact my technician and consult a physician at my own expense.

_____ I realize that variations in color may exist between the color selected and how it will ultimately look after my brows have healed.

_____ I understand that the procedure area will be dark for approximately the first six (6) days and will lighten thereafter.

_____ The final result will often not be obtained without returning for a touch up visit to reshape or augment areas within the brow.

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_____ The final appearance of the brow will be achieved 6-8 weeks after the final visit.

_____ Microblading will result in semi-permanent change my appearance (it usually lasts between 6 months to one (1) year) and that no representation has been made to me as to the ability to later change or remove the results.

_____ Skin Treatments such as laser hair removal, plastic surgery or other skin altering procedures may result in adverse changes to the procedure area.

_____ I am not currently under the influence of alcohol or recreational drugs.

_____ I do not have any type of rash or infection anywhere on my body.

_____ I have/will receive after care instructions and agree to follow them, I also agree that if I do not follow these instructions, any touch-up needed will be done at my own expense.

By signing below, you agree to the following:

I am over 18 years of age and consent to this agreement and to treatment. I have completed these forms truthfully and to the best of my knowledge. I acknowledge that I have been given full opportunity to ask any and all questions which I might have about the Microblading procedure, and that all my questions have been answered to my full satisfaction, I specifically acknowledge I have been advised of the facts and matters set forth.

Client Signature

Client Printed

Date

Esthetician Signature

Esthetician Printed

Date



MICROBLADING

Photo and Video Release Form

I, _____ hereby grant and authorize BRITNEY AL RASHID the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and/or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph recording.

I understand and agree that these materials shall become the property of the Esthetician and will not be returned.

I hereby hold harmless and release BRITNEY AL RASHID from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

Client Printed

Date

Client Signature

MICROBLADING

aftercare advice



Avoid make up and facial products on the treated area for 10 days.



Apply a thin layer of ointment on the treated area using a cotton swab.



Avoid touching or scratching the treated area.



Stay away from direct Sunlight. Wear a hat when going outside.



Keep the treated area dry for at least 10 days.



Attend your follow- up appointment.

Ilura Beauty Studio

f | |
@ilurabrowsandbeauty

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