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### Waxing Consent Form

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 (an oral form of Retin-a)? ☐ 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

What skin products do you regularly use on your skin?

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Are you currently being treated for chemotherapy and/or radiation? ☐ Yes ☐ No

Please list any other conditions currently being treated by a medical professional, that are relevant to skin waxing:

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I am willing to follow any recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician and/or a physician immediately. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the licensed esthetician, whose signature appears below, responsible for any of my conditions that were present, yet undisclosed at the time of this waxing procedure. I give my technician permission to perform this procedure and hold her harmless and nameless from any liability that may result from this treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Technician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Permission is granted to take photos of my eyes/face which may be used for marketing purposes:

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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