

# SunBrushedSprayTanning

## Consultation Form

### Personal Info:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

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

Cell phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Would you like to be added to our email list for special discounts? YES NO

How did you hear about us? \_\_\_\_\_

### Personal Medical History:

Do you have any of the following conditions (check all that apply):

- |                                   |   |   |   |
|-----------------------------------|---|---|---|
| <input type="checkbox"/> Eczema   | <input type="checkbox"/> Psoriasis            | <input type="checkbox"/> Dermatitis               | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Heart Conditions     | <input type="checkbox"/> Blood clotting disorders | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Lupus    | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Disorder         | <input type="checkbox"/> Skin Cancer    |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Any active infections    | <input type="checkbox"/> Sensitive skin |

Are you currently being treated for an illness/condition not listed above? YES NO

If yes, please describe: \_\_\_\_\_

Do you have known allergies related to Dihydroxyacetone (DHA)? YES NO

Do you have any other known allergies? YES NO

If yes, please describe: \_\_\_\_\_

Are you currently taking any medications or using any skincare products that may affect your spray tan? YES NO

If yes, please describe: \_\_\_\_\_

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### Tanning History

Have you previously had a spray tan? YES NO

If yes, when was your last spray tan appointment? \_\_\_\_\_

Have you experienced any adverse skin reactions from using self-tanning products or receiving a professional tan? YES NO

### Pre-Tan Preparation

Have you exfoliated your skin thoroughly before your appointment? YES NO

Have you shaved or waxed within 12-24 hours of your appointment? YES NO

Have you applied any moisturizers, oils, or lotions to your skin before the appointment? YES NO

Are you wearing makeup or any other products on your skin that need to be removed? YES NO

Do you wear contact lenses? YES NO

*If yes, please ensure that contact lenses are removed.*

### Skin Type

- skin burns easily, rarely tans       skin burns, then tans to light or medium  
 skin rarely burns, tans easily to medium or dark

### Skin Undertone

- Cool       Neutral       Warm       I don't know

Are you currently pregnant or nursing? YES NO

*Pregnant or nursing individuals are advised to consult with their physician prior to receiving any spray tan service.*

*I completed the above form to the best of my knowledge. I have had the opportunity to ask any questions and have received satisfactory answers. I will inform the technician of any changes to the above information. I am over the age of 18 and consent to the procedure. If I am under the age of 18, my parent/guardian must sign below. I will not hold the technician, salon, or employees liable for any injury or damage that may occur as a result of the spray tan procedure for any issues not disclosed at the time of my service.*

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if under 18)

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

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THE SPRAY TAN PROCEDURES ARE PERFORMED WITH THE PROPER TECHNIQUE, PRODUCTS, AND INSTRUMENTS, AND WITH YOUR SAFETY IN MIND. HOWEVER, THERE STILL ARE SOME RISKS ASSOCIATED WITH THE PROCEDURE. THIS CONSENT FORM IS INTENDED TO INFORM YOU OF THE RISKS OF THE PROCEDURE AND TO OBTAIN YOUR INFORMED CONSENT FOR THE PROCEDURE.

Initial:

\_\_\_\_\_ I understand that an allergic or adverse reaction to the spray tan procedure can occur. The symptoms can include, but not limited to, redness, swelling, irritation, itching, bumps, and/or tenderness. I understand the effects may be worse for people with sensitive skin or skin conditions.

\_\_\_\_\_ I agree to seek medical attention at my own expense if necessary.

\_\_\_\_\_ I acknowledge that DHA is the active ingredient in the tanning solution, which reacts with the amino acids in the top layer of my skin to produce a tan color.

\_\_\_\_\_ I understand that spray tanning is not a permanent solution, and I will require periodic maintenance sessions to maintain results.

\_\_\_\_\_ I understand that results of the procedure may vary and my final result may not be what I initially envisioned.

\_\_\_\_\_ I agree to the home aftercare procedure recommended by the technician.

*I completed the above form to the best of my knowledge. I have had the opportunity to ask any questions and have received satisfactory answers. I understand the risks and potential side effects associated with the spray tan procedure. I am over the age of 18 and consent to the procedure. If I am under the age of 18, my parent/guardian must sign below. I will not hold the technician, salon, or employees liable for any injury or damage that may occur as a result of the spray tan procedure or for any issues not disclosed at the time of my service. This agreement remains in effect for this procedure and any follow-up appointments.*

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if under 18)

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



# Cancellation Policy Form

In order to ensure the best service for all our clients, we do have a appointment cancellation and rescheduling policy.

We kindly ask for your understanding that when appointments are forgotten or canceled without adequate notice, it not only disrupts our scheduling efforts but also regrettably denies other clients on our waiting list the chance to experience our services.

When you schedule your appointments, you will be required to make a deposit of \$25, which will be applied as credit towards your treatments.

If you need to cancel or reschedule your appointment, please do so at least 12 hours before your scheduled appointment time. Your deposit can either be refunded or applied to a future appointment.

However, if you provide less than 12 hours notice, a cancellation fee of \$25 will be charged.

Arriving more than 15 minutes after your scheduled appointment time will be treated as a no-show, and a cancellation fee will be incurred.

I hereby acknowledge that I have read and fully understand the terms of this form and that I have had the opportunity to ask any questions that I may have before signing.

By signing this form, I certify that I am at least 18 years of age. If under 18 years of age, a parent or legal guardian must sign this form.

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Client Name

Client Signature

Date

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Parent/Guardian Name  
(if under 18)

Parent/Guardian Signature

Date