287 South Main St. Suite 7
Lambertville, NJ 08530

WAXING WAIVER

Name_____ Date:_____

Are you currently taking any of the following medications? *Please circle any that apply.*
Retin A Accutane Retinol

Have you had a skin peeling procedure in the past 6 weeks? Yes No
If yes, what type and when? _____

Have you had a professional wax service before today? Yes No

Have you ever had an adverse reaction to wax? Yes No
If yes, please explain _____

It is my choice to receive a waxing service. I understand that failure on my part to disclose information could result in injury and/or illness and I hereby release Zanya Spa Salon from any claims resulting from such. Any information provided to me by the Spa Therapist is for general education purposes only and is not intended for any medical purpose.

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