Dermaplaning Consent Form

Please initial each line next to each statement prior to treatment

_____ I understand that Dermaplaning is the process of removing superficial layers of dead skin cells and vellus hair on the skin's surface using a sterile blade.

_____ I understand that there may be unforeseen risks with Dermaplaning such as nicking, scraping, or abrading the skin with the blade.

_____ I understand that possible side effects of the treatment area can include mild redness of the skin, irritation, and dryness.

_____ I understand that if a chemical peel is part of this treatment, that the sensation and penetration of the peel will be enhanced. This may cause minor skin irritation, mild discomfort, and tenderness, lightening or darkening of the skin, peeling and activation of cold sores.

_____ I understand the results of this treatment may vary due to conditions such as age, condition of skin, sun damage, climate, etc.

_____ I understand that in order to see significant results these treatments need to be done in a series and in combination with using active ingredient skin care products.

_____ I understand that direct sun exposure, including tanning beds, is not recommended while undergoing treatment and the use of daily sun block protection is mandatory.

_____ I understand that any facial injections should be avoided 10 days before this treatment.

_____ I am not using Retin A®, Accutane or other retinol derivatives, such as Tretinoin, and have been off these products at least 3 days prior to treatment.

_____ I will call my practitioner if I have any questions or concerns about my treatment.

_____ I have been advised not to sweat the remainder of the day following my treatment. Avoiding saunas, exercise, and will use mild temperature water in shower.

_____ I will avoid contact with abrasive products including exfoliants, masks, beard hair, etc.

I agree to have this treatment performed on me. I further agree to follow all post-care instructions. Prior to receiving any treatment, I have been candid in revealing any condition that may have a bearing on this procedure. I am over 18 years of age.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____