



Dermaplaning Consent Form

I understand that Dermaplaning involves the use of surgical blade to remove fine vellus hair and dead layers of skin from the face.

I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Client will be notified and the area will be treated if necessary. The hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter normal hair growth pattern.

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

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age. I agree and adhere to all safety precautions and regulations during the skin treatment.

The service provider has the right to refuse service based on skin type, for example if skin is aged and loose or has active acne breakouts.

The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction.

I have received and understand the post care recommendations as follows: no tanning or sun exposure for 48 hours, moisturize as needed, use gentle cleanser only, Alpha and Beta Hydroxy acid (if desired) may be resumed 48 hours after treatment. Use of sunscreen is highly recommended post-treatment for at least the next 7 days.

Patient Signature: _____ Date: _____