



DERMAPLANING CLIENT CONSENT FORM

I _____ understand that Dermaplaning involves the use of a surgical blade to exfoliate the surface of the skin , and any villus hair. The nature , and purpose has been explained to me , and any questions I have regarding the treatment have been answered to my satisfaction.

I _____ understand 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. The hair that grows back will not be darker or thicker, however I do understand that any hormonal imbalance that may be present within my anatomical system can alter the 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. This may cause skin irritation, mild discomfort, tenderness, lightening of the skin, infection, scarring, 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 have read the above consent, and I fully understand it , and I hereby consent to the Dermaplaning treatment.

Client Signature _____ Print _____ DATE _____

Technician Signature _____ Print _____ DATE _____