Dermaplaning Consent Form

I, _____, give permission to the Estheticians of Southeastern Esthetics Institute to perform the dermaplaning procedure we have discussed and will hold him/her and his/her staff harmless from any liability that may result from this treatment. I understand he/she will take every precaution to minimize or eliminate negative reactions such as blisters, sores, or other reactions, as much as possible. I understand that dermaplaning utilizes an individual surgical blade to remove superficial dead skin from the stratum corneum, which is beneficial for sensitive and/or all skin types - and is safe for clients dealing with rosacea and/or telangiectasias/broken capillaries. I have given an accurate account of any over-the-counter or prescription medications that I use regularly and I am not presently using any topical medications such as, but not limited to, prescription-level Retin-A, Renova, Tazorac, or Tretinoin. I have not had any facial surgical procedures or other chemical peels or skin treatments that I have not disclosed to my therapist. I am not ingesting or using topically any other over- the-counter product or prescription medication/agent that has not been disclosed to my therapist. I am not presently pregnant or lactating and I am over the age of eighteen (18). I have not had any recent radioactive or chemotherapy treatments, sunburn, windburn, or broken skin. I have not recently waxed or used a depilatory (such as Nair) on the area to be treated. I do not have a history of keloidal scarring, excessive telangiectasia, rosacea, bacterial skin infections, fungal infections, viral infections, open lesions or rashes, active acne, any auto immune disease, or any other existing condition that may interfere with the positive outcome of this treatment. My expectations are realistic and I understand that the results are not guaranteed. I agree that I am willing to follow recommendations by my Esthetician for clinical-grade products for home use. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I acknowledge that I have been informed of the possible negative reactions and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately. I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I consent to the taking of photographs to monitor treatment effects, as desired or recommended by my therapist.

Yes _____ No _____

I hereby consent to the treatment of Dermaplaning with Southeastern Esthetics Institute for the treatments specified above.

Client Signature _____ Date _____

Provider Signature _____ Date _____

Physician Signature _____ Date _____

Revised March 2018