DERMAPLANING CONSENT FORM

I, _____ give my consent for the following procedure:

Dermaplaning to be performed by _____.

I understand there are contraindications to this treatment, including but not limited to, diabetes, cancer, active acne, bleeding disorders, and the inability for blood to coagulate following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellous hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts. While every precaution is taken, I understand the risks and consent to the treatment.

_____ _____

Name Signature

_____ _____

Date Witness