CHEMICAL PEEL CONSENT FORM

Date: ________________ Name: _________________________________ D.O.B:__________________

Emergency Contact Information
(Must be filled out to proceed with treatment.)

Name: _______________________________________ Phone#: ___________________________________

Relation: ______________________________________

Health Related:

☐ Yes ☐ No - Are you pregnant?
☐ Yes ☐ No - Are you planning to become pregnant?
☐ Yes ☐ No - Are you Nursing?
☐ Yes ☐ No - Do you have any metal implants or medical implants?
- If Yes, where is it located and what type of implant is it? ____

☐ Yes ☐ No - Do you smoke cigarettes regularly?
☐ Yes ☐ No - Do you use a vape or e-pen? (Nicotine or Marijuana)
☐ Yes ☐ No - Do you participate in vigorous aerobic activities or sports? How often: ____________X a Week
☐ Yes ☐ No - Have you had: ☐ Cold Sores ☐ Herpes ☐ Hives ☐ Keloids outbreak in the past 30 days?
- If Yes, when and where was your last outbreak: ____

☐ Yes ☐ No - Do you wear Contact Lenses? (Please remove contacts prior to treatment if eyes are sensitive.)
☐ Yes ☐ No - Do you wear sunscreen (SPF) on a regular basis?
☐ Yes ☐ No - Have you visited a tanning booth within the last week (If Yes, your service may have to be rescheduled.)
☐ Yes ☐ No - Have you received a spray tan within the last week? If Yes, When: _____________________
☐ Yes ☐ No - Have you been sunburned in the past two weeks?
☐ Yes ☐ No - Are you currently taking any antibiotics? (May increase sensitivity.)
☐ Yes ☐ No - Do you have any special functions you will be attending within the next 7 days?

Skin Care Related:

☐ Yes ☐ No - Are you currently using products containing Glycolic Acid or Alpha Hydroxy Acids?
- If Yes, how long have you been using the products and how has your skin reacted to it? ______________________

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Have you ever used Hydroquinone? (Skin Lightner) ☐ Yes ☐ No – How long ago? _______________________

Are you currently or have you use the following medications in the past 30 days?

☐ Accutane ☐ Avage ☐ Differin ☐ Renova ☐ Restylane ☐ Retin-A ☐ Tazorac

☐ Other Topical Retnoid/Vitamin-A derivative: ____

(Discontinue use 5-10 days before and after treatment - **NOTE: Consult your physician before discontinuing use of any prescription.**)
(If you have used any of these topical prescriptions within the past 30 days, we will need to reschedule your chemical peel)

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Do you currently use wax, electrolysis, or depilatories on your face? ☐ Yes ☐ No

• If Yes, when and what was your last treatment? ____________________

Have you had any of the following:				In the last 30 days?
Microdermabrasion	☐ Yes	☐ No	When: ____________	☐ Yes
Chemical Peel	☐ Yes	☐ No	When: ____________	☐ Yes
Laser Resurfacing	☐ Yes	☐ No	When: ____________	☐ Yes
Collagen or Botox	☐ Yes	☐ No	When: ____________	☐ Yes
Facial Surgery	☐ Yes	☐ No	When: ____________	☐ Yes
Permanent Make Up	☐ Yes	☐ No	When: ____________	☐ Yes

Have you ever had an allergic reaction to any of the following? (Select all that apply)

☐ A.H.A.s or B.H.A.s ☐ Animals (describe below) ☐ Cosmetics ☐ Drugs/Medication ☐ Food (describe below)
☐ Fragrance ☐ Iodine ☐ Latex ☐ Nuts/Tree Nuts ☐ Pollen
☐ Shellfish ☐ Sunscreen/SPF ☐ Other: ____________________

How would you describe your skin-type: (Check all that apply)

☐ Thick ☐ Thin ☐ Saggy ☐ Firm ☐ Sensitive ☐ Resilient ☐ Normal
☐ Dry ☐ Rosacea ☐ Eczema ☐ Oily ☐ Acne ☐ Prone to breakouts
☐ Combination ☐ Large Pores ☐ Small Pores ☐ Freckled ☐ Sun Damaged ☐ Acne Scarred ☐ Unevenness
☐ Melasma ☐ Psoriasis ☐ Wrinkled ☐ Mature ☐ Broken Capillaries ☐ Milia
☐ Congested ☐ T-Zone Congestion ☐ Hyper-Pigmentation ☐ Hypo-Pigmentation

What is your skin-tone: (Check all that apply)

☐ Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Olive
☐ Light Brown ☐ Med. Brown ☐ Dark Brown ☐ Black ☐ Other: ____________

What is your natural eye color:

☐ Blue ☐ Green ☐ Hazel ☐ Grey ☐ Light Brown ☐ Med. Brown ☐ Dark Brown

What is your natural hair color: (not the color it is currently dyed)

☐ White ☐ Black ☐ Blond ☐ Red ☐ Grey/Silver ☐ Salt & Pepper
☐ Light Brown ☐ Med. Brown ☐ Dark Brown ☐ Other: ____________ (Natural colors only please)

What is your daily skincare regimen:

Step:	Brand & Product Name:	How many times a week?	
Cleanser	____________	______ x a week	☐ AM ☐ PM
Exfoliation	____________	______ x a week	☐ AM ☐ PM
Mask	____________	______ x a week	☐ AM ☐ PM
Essence	____________	______ x a week	☐ AM ☐ PM
Serum	____________	______ x a week	☐ AM ☐ PM
Moisturizer	____________	______ x a week	☐ AM ☐ PM
SPF	____________	______ x a week	☐ AM ☐ PM

What improvements would you like to see in your skin? ____________________

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BY SIGNING BELOW, YOU AGREE TO THE FOLLOWING:

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A, Accutane, Differin, Tazorac, or Avage.

I understand there may be some degree of discomfort; i.e.: stinging, pin-prickling sensation, heat, or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may or may not actually peel, that each case is individual.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact Studio Skyn, LLC., or whoever performed the treatment.

I agree to refrain from tanning in tanning booths while I am undergoing treatment, and during the 14 days following the end of treatment. I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory.

I have not had any other chemical peel of any kind or microdermabrasion treatment within 14 days of the treatment. I understand I cannot have another treatment within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that Studio Skyn, LLC. does not offer massage as a form of therapy, nor is Studio Skyn, LLC a licensed massage therapy spa. Massages offered are included in services to assist in blood circulation and relaxation are not intended to be therapeutic in nature. Clients may refuse massages by notifying the esthetician before services are rendered.

I understand that certain skin conditions are recommended to be seen by a Licensed Dermatologist before skin treatments may be performed. I understand that estheticians are not licensed to diagnose or treat serious skin conditions, and will discuss options with me at the time of my service if necessary.

I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-peel care instructions as I am directed

This consent is also valid for all future chemical peel treatments for the remainder of this calendar year. I will also complete a "Form# SSCRTC" for each additional visit and inform Studio Skyn, LLC. of any changes required.

______________________________ ________________________ ______________

Signature of Client (Or Guardian) | Print Name (Relation if necessary) | Date

______________________________ Ryan DuPree FB9771808 ______________

Signature of Esthetician | Print Name | Date