**Dermaplaning Consent:**

I understand that Dermaplaning involves the use of surgical blade to remove fine vellus hair

and dead layers of skin from the face.

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 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. Patient 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 competent adult of at least 18 years of

age, or that, if I am a minor under the age of 18, I understand that the consent of my

parent/guardian having legal custody will also be required before treatment. I agree and

adhere to all safety precautions and regulations during the skin treatment.

I have received and understand the post care recommendations as follows: no 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 next 7 days. (SPF 30)

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_