Consent Form for Dermaplaning

I, _____ give my consent for dermaplaning to be performed by _____.

Please read and initial each of the statements below:
____ I certify I am over the age of 18.

____ I understand that dermaplaning is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built up dead skin cells and vellus hair. Following treatment skin will be smoother, softer and better able to absorb the active ingredients in treatment and home care products.

____ I have been informed of the nature, risks, and possible complications and consequences of dermaplaning. I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellus hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts.

____ I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate or the development of keloids 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.

____ While every precaution will be taken to avoid nicks, cuts and scratches, I understand the risks and consent to treatment today.

____ I understand that my technician only utilizes sterilized, disposable equipment to minimize the risk of infection or contamination and that my technician has received training in appropriate sanitation and hygiene techniques prior to performing any procedures. While the risk of infection from our procedures is extremely small, the possibility of such an occurrence cannot be totally prevented. Accordingly, I understand and accept the risk and releases my technician and the spa from any and all liability related to the subject procedure, except instances involving gross negligence.

____ I grant permission to _____, to take and use: photographs and/or digital images of me for use in news releases, educational materials and/or social media platforms including but not limited to Instagram, Facebook, Twitter, Tic Toc, and Pinterest.

By signing below, I agree to the following:

I have read or have had read to me the contents of this whole form. I understand the risks and alternatives involved in this/these procedure(s) and I have had the opportunity to ask questions and all of my questions have been answered. I accept full responsibility for the decision to have dermaplaning done and understand that there is a no refund policy. I acknowledge that I have reviewed and approved the material given to me.

Name Printed	Signature	Date
_____	_____	_____
Technician Name	Signature	Date
_____	_____	_____