



DERMAPLANING CONSENT FORM

I, _____ UNDERSTAND THAT DERMAPLANING
PATIENT / GUARDIAN'S FULL NAME

INVOLVES THE USE OF A STERILE DERMAPLANING BLADE TO EXFOLIATE THE SKIN SUPERFICIALLY AND REMOVE THE FINE, VELLUS HAIR ("PEACH FUZZ) FROM THE FACE.

I ACKNOWLEDGE THAT THE DERMAPLANING TREATMENT IS NOT AN EXACT SCIENCE AND THAT NO SPECIFIC GUARANTEES CAN OR HAVE BEEN MADE CONCERNING THE EXPECTED RESULT. I UNDERSTAND THAT THE DEGREE OF IMPROVEMENT IS VARIABLE AND ANOTHER FORM OF TREATMENT MAY BE REQUIRED.

I UNDERSTAND THE TREATMENT MAY INVOLVE RISK OF COMPLICATION OR INJURY AND I FREELY ASSUME THOSE RISKS. POSSIBLE SIDE EFFECTS OF THE TREATMENT CAN INCLUDE MILD REDNESS, MILD IRRITATION, AND DRYNESS. ADDITIONALLY, NICKS TO THE SKIN CAN OCCUR DUE TO THE SHARP SURGICAL BLADE. THE HAIR THAT GROWS BACK WILL NOT BE DARKER OR THICKER, HOWEVER, I DO UNDERSTAND THAT ANY HORMONE IMBALANCE WITHIN MY SYSTEM CAN ALTER THE NORMAL HAIR GROWTH PATTERN.

IF A CHEMICAL PEEL IS INCLUDED WITH THIS TREATMENT, I UNDERSTAND THAT THE SENSATION AND PENETRATION OF THE PEEL WILL BE ENHANCED TO ACHIEVE GREATER RESULTS. I UNDERSTAND THAT THIS MAY CAUSE SKIN IRRITATION, MILD DISCOMFORT, TENDERNESS, LIGHTENING OR DARKENING OF THE SKIN, INFECTION, SCARRING, PEELING, AND ACTIVATION OF COLD SORES WHEN THE VIRUS IS ALREADY PRESENT IN THE BODY.

I CERTIFY THAT I AM AT LEAST 18 YEARS OF AGE, OR I HAVE PARENTAL CONSENT CO-SIGNED BELOW.

I WILL CALL TO INFORM MY ESTHETICIAN OF ANY COMPLICATIONS OR CONCERNS AS SOON AS THEY OCCUR.

I HAVE READ THE CONTENTS OF THIS CONSENT FORM CAREFULLY AND I FULLY UNDERSTAND IT. I HEREBY RELEASE SHYLEE SKIN & WELLNESS AND ANY OF ITS EMPLOYEES AGAINST ANY AND ALL LIABILITY ASSOCIATED WITH THIS PROCEDURE. I HAVE BEEN ADEQUATELY INFORMED OF THE RISKS AND BENEFITS OF THIS TREATMENT AND WISH TO PROCEED WITH THE DERMAPLANING TREATMENT.

PATIENT'S FULL NAME

DATE

PATIENT / GUARDIAN'S SIGNATURE