Salon T. Daigle - Dermaplaning Consent Form

Please initial & sign below. Express any questions or concerns prior to the start of your treatment.

_____ I understand this procedure is a mechanical exfoliation involving a medical grade, surgical steel blade to remove vellus hair & dead skin cells from the skin's surface.

_____ I understand this procedure will remove the skin's barrier and leave the skin vulnerable; this means I understand I need to protect my skin with SPF (SPF in makeup or moisturizer is insufficient!)

_____ I understand I **MUST** follow the following guidelines;
-Discontinue use of Accutane for ONE YEAR prior to treatment
-NO facial waxing the treated area for 7-10 days PRIOR and POST treatment
-NO heavy exercise, chlorinated pools, hot tubs OR steam rooms for 48 hrs post treatment
-Discontinue use of Retinols for 3 days prior, & 3-5 days post treatment
-Discontinue use of Retin-A, Trentinoin, etc. for 5 days prior, & 7-10 days post treatment
-NO injectibles, fillers, etc. for 14 days pre and post treatment
-NO Laser treatment for one month post treatment

_____ I promise to inform my technician if I have been using any of the following medications;
-Antibiotics
-Allergy Meds
-Cold Meds
-Steroids (anywhere in the body, injected or topical)
-Aspirin

_____ I understand I cannot receive Dermaplaning if I have any of the following;
-Sunburn/Windburn
-Cold sores/Impetigo
-Active Rosacea
-Active Eczema
-Lupus
-Active Psoriasis/Dermatitis
-Keloids/Hypertrophic Skin

_____ I understand that my esthetician will recommend home care for optimal results. I understand results may not be attained from one treatment, and are best with a series of facials and/or treatments.

_____ I understand there may be unforeseen risks with this treatment such as nicks, scrapes, injury, etc. and I understand there may be possible side effects such as irritation & mild redness.

I certify that I have read this entire form and the information I have provided is true to the best of my knowledge. I certify that I am 18 years of age, otherwise parental consent is provided below. I release my technician from all liability associated with this procedure. I understand that I have been advised to follow aftercare protocol to avoid any discomfort or adverse side effects after the procedure has been completed. I hereby consent to the Dermaplaning treatment.

Date _____

Printed Name _____

D.O.B _____

Signature _____