

**Dermaplaning Consent Form**  
**Please initial each line next to each statement prior to treatment**

I understand I am receiving an exfoliation treatment using a sterile surgical blade.

I understand the possible side effects include but are not limited to: skin tightness, mild to moderate redness, mild flaking, possible nicks.

I understand this procedure removes most, not all vellus hair (peach fuzz)

I understand the results of this treatment may vary due to conditions such as age, condition of skin, sun damage, climate, etc.

I understand this treatment is a cosmetic treatment and no medical claims are expressed or implied.

I understand that direct sun exposure, including tanning beds, is not recommended while undergoing treatment and the use of a daily sun block protection is mandatory.

I understand that any facial injections should be avoided 10 days before this treatment. I am not using Retin A, and have been off Retin A for at least 3 days prior to treatment. I will call my practitioner if I have any questions or concerns about my treatment.

I have been advised not to exercise after my treatment.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-care instructions. Prior to receiving any treatment, I have been candid in revealing any condition that may have bearing on this procedure. I am over 18 years of age.

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

Print Name: \_\_\_\_\_

Medical Aesthetician: \_\_\_\_\_ Date: \_\_\_\_\_