**DERMAPLANE**

**DISCLOSURE & CONSENT FORM**

@BEAUTYBYSHAWNAOSUNA

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. PLEASE CALL YOUR PRACTITIONER WITH ANY QUESTIONS/CONCERNS ABOUT THE TREATMENT.

**PLEASE READ AND INITIAL THE FOLLOWING:**

**\_\_\_\_\_**I understand I am receiving an exfoliation treatment using a sterile surgical blade which removes most, not all vellus hair and as with the use of any sharp instrument, there is a possibility of nicks or cuts.

\_\_\_\_\_I understand the results of this treatment may vary due to conditions such as age, condition of skin, sun damage, climate, etc. and this treatment is a cosmetic treatment in which no medical claims are expressed or implied.

\_\_\_\_\_I understand with any beauty service there are inherited risks, including but not limited to allergic reactions. Understanding potential side effects may include; grazing, abrasions, skin sensitivity/redness, dryness or adverse reactions to products used during treatment.

\_\_\_\_\_I understand I must follow my aftercare to prevent potential skin irritations and 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 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, high doses 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.

\_\_\_\_\_I understand that in order to see significant results these treatments need to be done in a series and in combination with using active ingredient skin care products.

\_\_\_\_\_I understand that not providing the required information regarding what I do before or after the treatment may affect the results, and do not hold Shawna Osuna responsible.

Please check if you are using any of the following:

\_\_\_\_Vitamin A (retinol, retain A)

\_\_\_\_AHAs (Glycolic, Lactic, Mandelic)

\_\_\_\_BHAs (Salicylic acid),

\_\_\_\_Accutane

\_\_\_\_Skin antibiotics

\_\_\_\_Prescriptive face creams

\_\_\_\_Diabetic medications or blood thinners

\*Retin A, BHAs, AHAs MUST be stopped at least 3 days prior to this service\*

I agree to have this service performed on me. I further agree to follow all aftercare procedures. Prior to receiving treatment, I have been candid in revealing any condition that may have a bearing on this procedure. I am over the age of 18 years old.

CLIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_

PROVIDER SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_