Dermaplaning Consent Form

DECLARATION

Please read carefully, complete, sign and date this form prior to your treatment.

DOB: _____ dd / mm / yyyy

Information: This section of medical conditions should not be treated either straight away OR until the condition resolves itself or not at all with Dermaplaning.

Do any of the following conditions relate to you? Please tick the appropriate box:

Roaccutane or Accutane within the last 6 months

◯ No ◯ Yes

Allergy to shellfish

◯ No ◯ Yes

Any other allergies/intolerances

◯ No ◯ Yes

If yes; Please specify

Autoimmune disorders (HIV, Lupus, Hepatitis, etc.)

◯ No ◯ Yes

Pregnancy

◯ No ◯ Yes

Breastfeeding

◯ No ◯ Yes

Cancer or history of cancer

◯ No ◯ Yes

If yes; Please specify

Cold sores within the last month

◯ No ◯ Yes

Cosmetic injections within the last 2 weeks

◯ No ◯ Yes

Recent laser procedures in the treatment area

◯ No ◯ Yes

Recent deep chemical peels in the treatment area

◯ No ◯ Yes

Facial waxing with last 2 weeks

○ No ○ Yes

Retin A or Retinol products

○ No ○ Yes

Active eczema on the treatment site

○ No ○ Yes

Open wounds on the treatment site

○ No ○ Yes

Fresh scars on the treatment site

○ No ○ Yes

Blood thinners

○ No ○ Yes

Cortisone or steroid injections

○ No ○ Yes

Epilepsy

○ No ○ Yes

Light sensitive medication

○ No ○ Yes

Diabetic

○ No ○ Yes

Notes: Please specify here any other medical conditions we may need to be aware of:

CLIENT DECLARATION:

I have answered and understood the above medical questionnaire to the best of my knowledge and all information provided is correct.

Client signature

Practitioner signature

TREATMENT PERMISSION

I give permission for Jaye Bird Aesthetics to carry out the Dermaplanning treatment on myself and have read and understood the information about the treatment and the risks associated. (please initial):

☐ I acknowledge that I am not pregnant or breast feeding, haven't used Roaccatune within the last 6 months, haven't received any cosmetic injections with the last 2 weeks, I don't suffer from cancer and autoimmune disorders and do not have any known allergies to shellfish. I have specified any other allergies I have in the medical questionnaire form.

- [ ] 2. I have been given a full consultation and explanation of the Dermaplaning treatment and all my questions are answered.
- [ ] 3. I acknowledge that there is no guarantee to the results of the treatments and acknowledge the need for the continual care for the extension of treatment results.
- [ ] 4. I acknowledge that it is my responsibility to use a minimum of SPF 30 following my treatment.
- [ ] 5. I understand that there may be skin reactions to the ingredients or the treatment itself, and skin may experience temporary irritation, tightness, redness, itchiness and swelling. All of these affects will resolve themselves within days to weeks depending on the skin sensitivity.
- [ ] 6. I understand that it is my responsibility to avoid Retinol, Retin-A products pre and post Dermaplaning treatments for a minimum of 2 days.
- [ ] 7. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions.
- [ ] 8. I consent to the use of my before, during and after facial procedure photos for education and promotional purposes.

Client signature

Practitioner signature