fusion
Massage & Wellness

Dermaplaning Consultation and Release Form

Name: _____ *Phone:* _____ *DOB:* _____
Alternate Phone: _____

Address: _____ *State:* _____ *Zip code:* _____

Email: _____ *Would you like to receive emails about our monthly specials?* ☐ *Yes* ☐ *No*

How did you hear about us (friend/family name, internet search, Facebook, etc.)? _____

Occupation: _____ *Male* _____ *Female*_____

Emergency Contact: _____ *Phone:* _____

Have you used any of the following in the last 72 hours?

☐ *Glycolic Acids* ☐ *Alpha-Hydroxy Acids*
☐ *Retin A* ☐ *Salicylic Acid*
☐ *Benzoyl Peroxide* ☐ *Granular Scrubs*
☐ *Hydroquinone* ☐ *Acutane*

Please check all that apply:

☐ *Do you smoke?* ☐ *Facial Surgeries*
☐ *Contact Lenses* ☐ *Oiliness*
☐ *Dryness* ☐ *Sun damage*
☐ *Blackheads* ☐ *Broken Capillaries*
☐ *Skin tone/Elasticity Issues*
☐ *Product Sensitivity* ☐ *Recent Facial Waxing*

Do you have any of the following?

☐ *Active Acne* ☐ *Active infections (i.e. flat warts, herpes simplex)*
☐ *Raised Lesions* ☐ *Recent chemical peels*
☐ *Chemo or Radiation* ☐ *Eczema*
☐ *Dermatitis* ☐ *Hypertonic Scarring*
☐ *Keloid Formation* ☐*Hemophilia*
☐ *Facial moles* ☐ *Taking oral blood thinners*
☐ *Pregnancy* ☐ *Rosacea*
☐ *Scleroderma* ☐ *Skin cancer*
☐ *Facial Tattoos* ☐ *Telangiectasia/erythema*
☐ *Sunburn* ☐ *Thick, dark facial hair*
☐*Vascular lesions* ☐ *Uncontrolled diabetes*

Please explain any check marks above: _____
_____
_____
_____

Please turn over ➡

fusion
Massage & Wellness

I understand that Dermaplaning involves the use of surgical blade to remove fine, vellus hair and dead layers of skin from the face. The nature and purpose of this treatment has been explained to me, and any questions I have regarding the treatment have been answered to my satisfaction. *Client initials* _____

I understand that the treatment may involve the risk of complication or injury, and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Client will be notified, and the area will be treated if necessary.
Client initials _____

The hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter normal hair growth pattern.
Client initials _____

If a chemical peel is part of this treatment, I understand that the sensation and penetration of the peel will be enhanced, which may cause skin irritation, mild discomfort, and tenderness, lightening or darkening of the skin, infection, scarring, peeling, and activation of cold sores. *Client initials* _____

If you have additional questions or concerns regarding your treatment or suggested post-care instructions, you will consult with your esthetician at Fusion Massage & Wellness immediately. *Client initials* _____

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I am competent adult of at least 18 years of age, or that, if I am a minor under the age of 18, I understand that the consent of my parent/guardian having legal custody will also be required before treatment. I agree and adhere to all safety precautions and regulations during the skin treatment. I have received and understand the post care recommendations as follows: no sun exposure for 48 hours, moisturize as needed, use gentle cleanser only, and use of sunscreen post-treatment for at least the next 7 days (SPF 30 minimum).

Signature _____

Print name _____

Date _____