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Dermaplaning Consent Form

PERSONAL INFORMATION:

Title _____ First Name _____ Surname _____

Address _____

Suburb _____ Postcode _____ State _____

Occupation _____ Email Address _____

Mobile _____ Home Ph _____

Date of Birth _____ Ethnic Background _____

Family Doctor Name and Contact No: _____

Emergency Contact Name and Telephone _____

How did you hear about us? _____

MEDICAL HISTORY:

Do you have any of the following conditions: *If yes, please select them:*

- | | |
|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hyper/hypo pigmentation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Blood/clotting disorder | <input type="checkbox"/> Immune disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Keloid scarring |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Metal bon pins/plates |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Skin disease/lesions |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Seborrhoea |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Warts |

Any other conditions _____

Any known allergies? No Yes

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List any medications you take regularly, including vitamins, herbal supplements, aspirin etc:

Any recent surgeries, including plastic surgery? No Yes, explain

Are you pregnant, trying to become pregnant or breastfeeding? No Yes

SKIN HISTORY:

Have you ever had a facial treatment before? No Yes

If yes, when and please explain:

What are your skin goals?

What is your skin type? Normal Oily Dry Combination Mature

Your exposure to the sun? Never Light Moderate Excessive

Foundation you wear: Liquid Cream Powder None

How does your skin heal? Fast Slow Moderate

Do you bruise easily? No Yes

Please tick the current products you use:

- | | | |
|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Cleanser | <input type="checkbox"/> Facial soap | <input type="checkbox"/> Sheet masks |
| <input type="checkbox"/> Exfoliants | <input type="checkbox"/> Skin toner | <input type="checkbox"/> Retinol |
| <input type="checkbox"/> Serums | <input type="checkbox"/> Eye cream | <input type="checkbox"/> Day/night creams |

Have you ever used acne medication? No Yes

If yes, when? _____ list the name/s _____

In the last 3 months, have you used Retin-A, AHA's or Retinol/Vitamin A derivative products? No Yes, please describe

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

No Yes, please specify:

About the procedure

Dermaplaning is a non-invasive exfoliation treatment that removes dead skin cells and fine vellus hair (peach fuzz) using a sterile surgical blade. This helps improve skin texture, enhances product absorption, and creates a smoother complexion.

Risks

While dermaplaning is generally safe, potential risks include temporary redness, sensitivity, minor cuts, or irritation. Rarely, breakouts or uneven skin texture may occur after treatment.

Infection

Infection risk is minimal when performed in a sterile environment by a trained professional. Keeping the skin clean post-treatment and avoiding touching the face with unclean hands helps prevent infection. You MUST avoid sun exposure immediately after the treatment. You should also wear a daily SPF +30 and avoid picking and/or peeling the skin during healing period.

Scarring

Scarring is extremely rare but may occur if the skin is injured or if there is an underlying skin condition. Clients prone to keloid or hypertrophic scarring should consult with their practitioner before treatment.

Pain

Dermaplaning is a painless procedure. Some clients may experience a mild tingling or scraping sensation, but there is no discomfort during or after treatment.

Mild redness, sensitivity, and slight swelling are normal after dermaplaning and typically subside within 12–24 hours. Itching or tingling may also occur as the skin heals. However, receiving treatments less than four weeks apart may lead to prolonged sensitivity or irritation.

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- I understand dermaplaning is a temporary exfoliation treatment and will not permanently improve skin texture, tone, elasticity, hyperpigmentation, or scars, or minimise fine lines and wrinkles. While it provides immediate smoothness and radiance, its effects are not long-lasting. It's important to have realistic expectations and understand that dermaplaning has limitations. For more significant or lasting results, additional treatments and ongoing maintenance may be required.
- I have not had any unprotected sun exposure in the last 2 weeks I have disclosed with my technician if I am on any medications.
- I do not have a history of keloid scars.
- I do not have any form of clotting disorders or taking blood thinners.
- I have not used Retin A in the last 2 weeks.
- I have not had any laser resurfacing or chemical peels in the last 4 weeks.
- I have not had any Botox or injectable fillers in the last 4 weeks.
- I am not pregnant or breastfeeding.
- I am not a diabetic.
- I have made my clinician aware of any illnesses or medical conditions to the best of my knowledge.
- I understand there are no refunds on any performed service.
- I agree to inform my therapist of any changes throughout the course of my treatments.
- In relation to my treatment, I have been advised as follows...
- Treatment is successful on most clients, but my individual results cannot be guaranteed.
- Exposure to UV rays can compromise my treatments, therefore I will wear SPF + 30 daily.
- To follow after care as instructed to receive best possible outcome.
- Understand there may be possible side effects/risks
- I have read all the above and have had all my questions satisfactorily answered.

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform my therapist of any changes to the above information. I agree to waive all liabilities toward my skin therapist and the employer for any injury or damages incurred due to any misrepresentation of my health history.

Do not sign this form until you have read and understood all the above.

Name _____ Date _____

Signature _____