salon U

Dermaplaning

Consent & Liability Waiver

Full Name:_____D.O.B.(mm/dd/yyyy):_____

Phone Number: _____ Email: _____

Address:_____ City: _____ Province:_____

Postal Code:_____

Photo Release(MANDATORY): I,_____ <print full name> _____ , understand and accept that as a part of my service, all or part of the service may be recorded and photographed. As such, it will be property of Salon U Regina and Emerald Park. I understand that these videos and photos will be used for learning, advertising, liability records and all other business purposes. By signing this, I consent to having my picture and/or video taken during this service and authorize the use for all business purposes of Salon U Regina and Emerald Park

_____Signature_____

Have you used or had any of the following?(Please check all that apply)

___Accutane	___Sunburn	___Microdermabrasion	___Ultrasound Skin Tightening
___Retin-A or Retinol Products	___Chemical Peel	___Microneedling	___Permanent Makeup
___Retin-A Burns	___Laser Resurfacing	___BBglow	___Microblading
___Glycolic Acid	___Photo Facial	___Dermaplaning	___Lash Enhancement Serums
___Laser or IPL Treatments	___AHA/BHA	___Botox and/or Filler	___Lash Extensions
___Electrolysis	___Blood Thinners	___Chemotherapy	___Radiation

When?_____

Medical Information(Please check all that apply)

___In Menopause	___Breast Feeding	___Hypo/Hyperglycemia	___Hypo/Hyperpigmentation
___Post Menopause	___Latex Allergy	___Fybromyalgia	___Cancer(Current or Past)
___Regular Periods	___HIV/AIDS	___High/low blood Pressure	___Diabetes
___Hormone Imbalance	___Herpes/Cold Sores	___Bleeding Disorder	___Heart Conditions
___Pregnant	___Hepatitis A,B, or C	___Keloid Scar(s)	___Pacemaker
___Mental illness (Depression, anxiety, etc.)	___Anemia	___Epilepsy	___Nut Allergy

Details_____

Please list all other current health conditions as well as any pharmaceutical and homeopathic medication or supplements:_____

_____

I declare that the above information provided is accurate and true to the best of my knowledge

Signature:_____ Date:_____

Dermaplaning

Please read thoroughly and INITIAL to agree, acknowledge and accept the following:

____I agree that the decision to undergo this procedure is my choice alone.

____I am not on blood thinners. I am aware there is a risk of cuts or nicks.

____I understand that mild redness and irritation may occur in the area of treatment and usually subsides within 12-72 hours.

____I am not under the influence of drugs or alcohol.

____I do not get cold sores or have Herpes, and if I do, I understand the risks.

____I currently do not have any type of infection or rash anywhere on my body.

____I do not have a history of keloid scars.

____I do not have diabetes or a history of hemophilia/abnormal bleeding.

____I consent to have _____technicians name_____ perform the procedure and also to any actions or conducts that are reasonably necessary to perform this procedure.

____I understand that an allergic reaction to the products used during this procedure are rare but may occur. I accept the risk that such a reaction is possible.

___I have not used any anti-aging creams in the last 24 hours.

___I understand that any payment made to Salon U is non-refundable under any circumstance.

___I fully understand the procedure being done. Including, but not limited to, the treatment itself, aftercare instructions, and risks.

___I acknowledge that I have been given the opportunity to ask questions, and that all of my questions have been answered to my satisfaction.

___I certify that I have been given a physical form of sufficient post-care information and if lost, have the ability to retrieve the post care information from the Salon U website and agree to follow all instructions carefully.

I hereby release,_____technicians name_____, Salon U, all technicians,and employees from any and all actions, claims and demands for damages, loss or injury, which I could have, or may have in the future arising out of or in any way relating to any and all injuries, loss or damages that may develop in the future relating to any personal service provided by _____technicians name_____at Salon U.

I certify that I have read the information form thoroughly, that I fully understand it and that by signing below I have the capacity to provide consent, and that I am providing consent freely and voluntarily.

Signature:_____ Date:_____

Technicians Signature:_____