Informed Consent & Release for Waxing

Name: ____
First Middle Last

Address: ____
Street City State Zip

Phone: (h)____________________ (w)____________________ (c)____________________

DOB: _______/_______/_______ How did you hear about us:______________________________

Email: ____

Are you currently using Retin-A or a retinoid product?	Y	N
Are your currently taking Accutane or have you taken it within the last six months?	Y	N
Are you currently under the care of a physician or another skin care provider concerning a skin disorder/ Disease with the last six month?	Y	N
If yes, please explain:		

________ I agree to keep the newly waxed are(s) out of direct sunlight or I will wear an SPF 15 or greater for at least 24 hours post waxing.

________ I am aware of the following possible experiences/risks to waxing:

- Scabbing
- Pigment changes (hypo pigmentation)
- Scarring
- Redness
- Papules & Pustules

________ My questions regarding waxing have been answered to my satisfaction by my Skin Care Specialist.

________ I recognize EVERY individual will have a different experience. After treatment, hair growth cycle may lessen or increase due to several factors like stress, medication, changes in lifestyle, or, dormant hairs may start their growth cycle.

By signing below, I have acknowledged reading and agreeing to the above terms.

____
Client Signature Date

____
Skin Care Specialist Signature Date

Revised March 1, 2014