# AUTHORIZATION AND CONSENT FOR WAXING

**PLEASE READ THIS AUTHORIZATION CAREFULLY AND ACKNOWLEDGE YOUR UNDERSTANDING BY SIGNING YOUR NAME IN THE SPACE BELOW.**

To The Client. You have the right to be informed about the procedure to be used, indicating risks and benefits, so that you may make the decision whether or not to undergo the procedure. This authorization and consent form is an effort to make you better informed. To that end, you are encouraged to ask any questions you may have. You are also encouraged to conduct your own research or consult with your own health care provider if you have additional questions.

Procedure. Waxing is a procedure to remove unwanted hair from its roots. In some areas hot, "soft" wax is applied to the skin, and a strip of cloth or paper is pressed into the preparation. The strip is then quickly pulled away, taking hairs with it. In other areas hot, "hard" wax is applied to the skin and allowed to cool. The cooled wax is then quickly pulled away, taking hairs with it.

**Possible Side Effects**. I understand that this procedure(s) may cause side effects. The side effects listed here are merely examples and are not intended to be an exhaustive list. Every person is different, and there is no guarantee that more severe side effects will not occur. Of the observed side effects, the most common are listed. You may experience quickly-dissipating, mild discomfort when the wax removes hair from its root. Taking antibiotics may **make skin more sensitive** and susceptible to some **skin lifting**. Please be aware that waxing may cause **inflammation**, **welts**, **hives**, **skin lifting**, and **reddening** or **small breakouts** due to bacteria being pulled out with the hair or sensitivity or allergy to the wax. This is usually not severe and may subside within a few days. If you have reaction, apply a topical antibiotic such as Neosporin, and apply ice, stay out of sun and use a SPF 30 sun block. Call if not resolved within a few days. Use of an AHA cleanser or other AHA product may help prevent ingrown hairs.

Patient Questionnaire. By my signature below, I certify that the answers given herein are true and complete to the best of my knowledge.

Are you pregnant? ☐ Yes ☐ No
Are you trying to become pregnant? ☐ Yes ☐ No
Are you currently taking any antibiotics? ☐ Yes ☐ No
If so, please list and state the date you started taking the medication: _____
_____

Do you have any allergies, including an allergy to wax? ☐ Yes ☐ No
If so, please list: _____
_____

Have you taken accutane within the past two (2) months? ☐ Yes ☐ No
Are you taking any topical acne medicine, including Differin, Retin A, glycolic treatments, prednisone, or corticosteriods (i.e. elocon, kenalog)? ☐ Yes ☐ No
If so, please list: _____
_____

Do you have diabetes? ☐ Yes ☐ No
Have you been tanning within the past 24 hours? ☐ Yes ☐ No
Do you have any skin sensitivities? ☐ Yes ☐ No
If so, please list: _____
_____

Authorization. I hereby authorize Skinology LLC, its employees, and agents to perform the waxing procedure(s) on me. I fully understand that this procedure has limited applications. I am aware that the practice of esthetics, like medicine and surgery, is not an exact science, and I acknowledge that reputable practitioners cannot properly guarantee quality and/or results or freedom from complications. I acknowledge that I have had the opportunity to ask questions, and that I fully understand the waxing procedure.

Waiver. I understand and acknowledge that there are risks involved with the waxing procedure(s), including, but not limited to, those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby waive Skinology LLC's liability if such results or complications occur. I further understand that my failure to follow post-procedure instructions may also lead to undesired results, complications or effects and hereby waive Skinology LLC's liability if such results or complications occur. In consideration for Skinology LLC performing this procedure(s), I agree that I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure(s) or side effects I may experience after the procedure(s) is performed. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against Skinology LLC, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure(s).

**I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure(s) described above.**

| Client Signature | Printed Name | Date |
|---|---|---|

| Signature of Parent/Guardian (if under 18) | Printed Name | Date |
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| Witness Signature | Printed Name | Date |
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