Chemical Peel Consent Form

Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

Esthetician Administering Treatment:_____

PROPOSED TREATMENT:

I understand that a superficial chemical peel may be useful in improving the appearance of the skin, may reduce the appearance of fine lines and wrinkles and diminish pigmentary irregularities. **Initials:_____**

ANTICIPATED BENEFIT:

I am undergoing this peel in an effort to improve my skin texture and color. I understand that the results of this treatment vary according to age, condition of skin, sun damage, smoking and climate. I may achieve some improvement in my fine wrinkles as well, but no guarantee has been made to me regarding my level of improvement from this peel. **Initials:_____**

I have received the Chemical Peels Care Sheet as to how to care for my skin prior to and following this treatment and agree to abide by the provisions. I understand that proper sun protection including, but not limited to, consistent use of broad spectrum UVA-UVB sun block with a minimum of SPF 45 is vital to proper after care and the reduction of risks of undesired side effects. **Initials:_____**

RISKS AND COMPLICATIONS:

I understand that there is a small risk of developing: temporary or permanent pigment (color) change in the skin, reactivation of "cold sores" (herpes infections) in individuals with a prior history of herpes, flare of acne-like lesions, and slight possibility of scarring and/or infection. I understand I should not "pick" at any scabbing that may result, to minimize the potential of scarring or infection. **Initials:_____**

I understand that chemical peels generally only cause 1 to 2 days of mild redness with areas of flaking or peeling skin. On rare occasions this peel can penetrate deeper in certain areas. **Initials:_____**

LIMITATIONS AND ALTERNATIVES:

I understand that there is a possibility that this treatment may be unsuccessful and generally requires additional treatments to achieve optimal results. **Initials:_____**

I am NOT: allergic to salicylates (e.g. aspirin), pregnant or lactating. **Initials:_____**

PHOTOGRAPHS:

I agree to having photographs taken of my skin for use either in teaching or to evaluate treatment effectiveness. NO photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission. **Initials:_____**

I have read the above information and understand it. The treatment as well as potential benefits, risks, and alternatives have been explained to me by my Esthetician and I have had all my related questions satisfactorily answered by my Esthetician. I hereby freely consent to the treatment and accept the risks and possible complications of such treatment.

Client Name Printed -Date and Time	**Witness Signature Date**
Client Signature	**Esthetician Signature Date**