

Name _____ **Date** _____

Waxing is a method of temporary hair removal which removes the hair from the root.

My Esthetician has explained the treatment to me and I understand that this is a hair removal treatment.

I am aware that discomfort may occur. If discomfort is experienced, I will inform the operator.

I am aware that waxing may have some side effects including, but not limited to, redness, scabbing, bruising, scarring, swelling, tenderness, hyper-pigmentation, flaking and/or pimples.

I understand that this is a procedure that does not need to be performed by a physician.

I agree to follow all post-treatment home care instructions.

I agree to apply a sunblock with an SPF of 15 (minimum) after the procedure.

I agree to avoid the following after the waxing procedure: saunas, steam rooms, hot tubs or other heat sources; avoid application of Retin-A, Renova or AHA products for 48 hours; avoid using a loofah or other abrasives on the waxed area.

I have given an up to date and honest account of my medical history and doctor prescribed medications.

I have read and understand all of the above and agree to have this treatment.

Client Signature _____

Witness _____