Informed Consent

BREATHE with Janell Classes

Name_____Age/Date of Birth: _____

Cell Phone_____ Email: _____

Address: _____

Please read and initial the following statements. Signature is required. This form should be returned to the Clinic Reception Desk no later than 1 day prior to your first class.

- Breathwork, as with any type of exercise, is a potentially hazardous activity. I have been informed and acknowledge that I am voluntarily choosing to participate in this activity at my own risk**.** **X_____**
- I understand that breathwork can result in intense physical and emotional release, therefore it is not advised for persons with a history of cardiovascular disease, including angina or heart attack, high blood pressure, glaucoma, retinal detachment, osteoporosis, or any significant recent physical injuries or surgeries. Breathwork is not advised for persons with severe mental illness or seizure disorders or for persons using major medications.
  Breathwork is unsuitable for anyone with a personal or family history of aneurysms. **X_____**
- Pregnant women are advised against practicing Breathwork without first consulting with and getting approval from their primary physician before attending breathwork training. **X_____**
- Persons with asthma should bring their inhaler and consult with their primary care physician and Breathwork facilitator before their first session.
- I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation. **X_____**
- I acknowledge that I have decided to participate in the activity without the approval of my physician and do hereby assume all responsibility for my participation and activities **X_____**
- I understand Total Health staff need accurate information from me in order to implement appropriate exercise programming for my individual needs, and I have provided this information to the best of my ability**.** **X_____**

Do you have a history of:

___Asthma ___ Osteoporosis
___Back Pain ___Tendonitis
___Neck Pain ___Arthritis
___Cancer ___High/Low Blood Pressure
___Current Pregnancy ___Pinched Nerve
___Total Joint Surgery ___Recent Surgery/Precautions
___Glaucoma ___Cardiovascular Problems
___Bipolar Depression ___History of Aneurysm
___History of Seizures ___ Taking heavy medications
___Active Addiction ___A mental illness for which treatment or support is lacking in any manner.

Please indicate any medical conditions or activity restrictions that may preclude you from doing this exercise. *It is important this information be as complete as possible.*

_____
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_____
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I hereby certify that I have read the contents of this Informed Consent and Release of Liability, and I agree to be bound by the reasonable rules and regulations adopted by Total Health Nutrition Center and Wellness Clinic in connection with the use of its facilities and equipment, electronics, either in person or virtually. I agree that the foregoing obligations shall be binding of me personally, as well as upon my family and my heirs, executors, administrators, and assigns.

Participant's Signature: _____Date: _____

Instructor Signature: _____Date: _____

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