YOGA & YOU

FIND YOUR INNER SELF

PRENATAL YOGA CONSENT FORM

CONFIDENTIAL

SEPTEMBER 8, 2020

YOGA & YOU
MELBOURNE, AUSTRALIA

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Personal Information

Full Name _____

Phone number _____

Email address _____

Emergency contact Name _____

Emergency contact Number _____

Health history

Do any of the following apply to you? Please tick all relevant conditions:

- ☐ Asthma
- ☐ Neck/Back problems
- ☐ Stroke
- ☐ High blood pressure *
- ☐ Epilepsy
- ☐ Overweight
- ☐ Sedentary lifestyle
- ☐ Smoker
- ☐ Heart condition *
- ☐ Arthritis
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Dizziness *
- ☐ Low blood pressure
- ☐ Chest pain *
- ☐ Joint problems
- ☐ Eye problems
- ☐ Bone/Joint damage *

* Please Note: If you tick any of the above marked with an Asterix *, I require a note from your health practitioner to allow you to participate in any yoga or fitness related activities. You are not permitted to attend a Yoga & You class until clearance is obtained.

Further Details

If you ticked any of the above, please provide further details:

Does your family have a history of any of the conditions above?

☐ Yes ☐ No

If yes, please provide details: _____

Is this your first pregnancy?

☐ Yes ☐ No

Due date of the baby: _____

Have you had complications with any previous pregnancies or history of miscarriage?

☐ Yes ☐ No

If yes, please provide details: _____

Have you had complications with any previous pregnancies or history of miscarriage?

☐ Yes ☐ No

If yes, please provide details: _____

Do you have any injuries or recent surgeries that may restrict your yoga practice?

☐ Yes ☐ No

If yes, please provide details: _____

Are there any other medical conditions, physical restrictions or special considerations?

☐ Yes ☐ No

If yes, please provide details: _____

Informed Consent

I certify that I have given my treating physician the written information about this class and have obtained the approval of my treating physician to participate.

I understand that I will not be able to enroll or to continue in this class without the prior written permission of my treating physician. I agree to keep my physician informed of the effects of this class on my body and to consult him/her whenever necessary.

During class, I agree to limit my activity to that which is comfortable for me and to stop all activity immediately if I feel uncomfortable. Upon experiencing any discomfort at any time either during or after class, I will immediately contact my treating physician to inform him/her and seek medical advice.

I understand that all forms of exercise involve some risk of injury. I accept complete sole responsibility for my health and wellbeing in this voluntary program.

In consideration of my participation in _____ (Name of your class), I, for myself, my heirs and assigns, hereby release and discharge _____ (Name of your class) from any and all liability now or in the future except insofar as permitted by law.

This release includes, but is not limited to, heart attacks, muscle strains, fractures, shin splints, musculoskeletal injuries, heat prostration, or any injury to myself, and my unborn child unless caused by the negligence, Save as otherwise stated, I hereby knowingly and voluntarily waive any and all claims against (name of your class) and its staff, agents and/or officers. Information regarding my health status will be treated as confidential and will not be released to any person other than program staff without consent.

Acceptance and Signature

Full Name _____

Signature _____

Date _____