Minor(s) / Child(ren)'s Information

Name(s):

_____Date of Birth: ___/___/___Age:____

_____ Date of Birth: ___/___/___Age:____

_____ Date of Birth: ___/___/___Age:____

Address: _____

City/State/Zip:

_____

Phone: _____

e-mail:_____

Emergency Contact Person: _____

Emergency phone: _____

Relationship to emergency contact: _____

Energia Wellness Studio may publish my child(ren)'s photo and/or videos in promotional newsletters, directories, social media, TV commercial or printed materials.

( ) Yes ( ) No

Adult and Minor Relationship: _____

Adult Parent or Legal Guardian Name:_____

Adult Parent or Legal Guardian Signature: _____

Date:_____/_____/_____

**** for their own safety, children are not allowed on the exercise equipment****

Waiver and Release - Minor/Child

I, as parent or legal guardian of the minor/child(ren) listed below agree that the listed minor/child(ren) will abide by the rules of the wellness studio, including the completion of health/medical information questionnaire prior to their participation in any physical activities at the wellness studio. I agree that all use of the wellness studio facilities, programs, and services that are undertaken by the listed minor/child(ren) will be done so at my sole risk and that the wellness studio shall not be liable for any injuries, accidents, or death occurring to my minor/child/(ren), including those caused by the wellness studio's negligence, arising either directly or indirectly out of participation in, or use of, the wellness studio facilities, programs, and services. I, as parent or legal guardian for the listed minor/child(ren) and on behalf of them, their parents or legal guardians, their executors, administrators, heirs, and assigns, do hereby expressly release, discharge, waive, relinquish, and covenant not to sue the wellness studio, its affiliates, officers, directors, employees, and agents for all such claims, demands, injuries, damages, or causes of action, including those resulting from the wellness studio's negligence, arising either directly or indirectly out of their participation in, or use of, the wellness studio's facilities, programs, and services.

I declare that I have completed the wellness studio's pre-activity screening questionnaire and/or health/medical information questionnaire for my minor/child(ren) and declare that they are physically able to participate in physical activity.

Furthermore, I knowledge, that the wellness studio has advised me to obtain a physician's clearance in the event the answers on either the pre-activity screening questionnaire and/or health/medical information questionnaire indicates that they should not participate in a program of physical activity without a physician's clearance, or if I am unsure of the

listed minor/child(ren)'s physical health yet maintain that he/she is physically capable of pursuing physical activity in the wellness studio without such steps being take or has done so.

If my child(ren)'s is/are participating in the yoga program I understand that supportive and encouraging touch, massage, and partner and group interaction is an integral part of this class.

Minor Child(ren):_____

_____

_____

_____

Adult and Minor Relationship:

_____

Adult Parent or Legal Guardian

Signature:_____

Date:_____

Staff Witness Signature:_____

Health Information Form for Minors/Children

(Please fill out one health history form for each child)

I/we, the undersigned parents/legal guardians of the minor/child named_____ hereby disclose the following health and medical information pertaining to this minor/child for use by the wellness studio while said minor/child is under the supervision of the wellness studio.
Child's date of birth:_____ Gender:_____

Allergies ( ) yes ( ) no
If yes, please describe: _____

_____

doTerra Essential Oils and Organic lotion may be applied on my child(ren) skin during yoga classes. i.e: foot massage.

( ) yes ( ) no

Physical limitations ( ) yes ( ) no
If yes, please describe: _____

_____

_____

Special medical conditions/considerations ( ) yes ( ) no
If yes, please describe: _____

_____

_____

Child's blood type (please circle if known) A B AB O
Physician's name: _____
Physician's address: _____
Physician's contact number: _____