Parent Massage Program
Chair Massage Informed Consent and Intake Form

Name: _____ Contact phone: _____

Address: _____
City State ZIP

Are you 18 or older	☐ No	☐ Yes
Are you currently pregnant?	☐ No	☐ Yes – How many weeks? _____
Do you currently have a cold/flu or fever?	☐ No	☐ Yes
Are you experiencing pain?	☐ No	☐ Yes – Where? _____
Do you have any skin allergies/rashes?	☐ No	☐ Yes
Do you have any recent injuries?	☐ No	☐ Yes – Where? _____

Informed Consent

I understand the purpose of this massage (neck and shoulders) is for stress reduction, increasing circulation or energy flow, and relaxation only. I understand that massage therapists will not provide medical diagnoses. I waive and release Seattle Children's, its staff and volunteers who are operating this massage program from any and all claims, suits, losses and related cause of actions for damages arising in any way, direct or indirect, from this massage program. For participation in repeated scheduled massage appointments, this authorization shall be in effect **for a period of three (3) months** from the date this release of liability is signed.

By signing below I acknowledge that I have read this document in its entirety (or that it has been read to me) and understand the content of this waiver and informed consent agreement.

Client signature: _____ Date: _____

Repeat visits:

Client initial: _____ Date: _____ Client initial: _____ Date: _____

Client initial: _____ Date: _____ Client initial: _____ Date: _____

Client initial: _____ Date: _____ Client initial: _____ Date: _____

Seattle Children's offers interpreter services for Deaf, hard of hearing or non-English speaking patients, family members and legal representatives free of charge. Seattle Children's will make this information available in alternate formats upon request. Call the Family Resource Center at 206-987-2201.

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