



MINOR RELEASE/WAIVER

Please sign completed form. Email to lmanning@chesapeakeholistic.com or fax to 410-757-6742 – before your appointment.

This should be completed *prior to your appointment*, to enable effective time-scheduling for your session and for other clients.

All persons under the age of 18 are required to have a parent or guardian fill out this form.

Disclaimer

By signing below, you are stating you are the parent or legal guardian of the minor receiving treatment(s) at our facility.

You understand that you are required to remain at the facility for the entirety of the minor's treatment(s). You will also be required, if needed, to assist the minor in preparing for his/her treatment(s). We may also request that you remain in the treatment room to supervise all interactions between the therapist and the minor.

You also agree that you have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s).

The programs and services Chesapeake Holistic offers are not substitutes for medical advice or physician-prescribed treatment. Our programs and services should not be construed as medical advice, and Chesapeake Holistic disclaims any liability from/in connection with this information. As with any program, if at any point you experience physical discomfort, you should stop immediately and consult a licensed medical practitioner. Individual results may vary, and past performance is not an accurate predictor of future results. No statements or claims made by employees or representatives of Chesapeake Holistic Health have been evaluated by the United States Food and Drug Administration.

PLEASE PRINT/TYPE CLEARLY:

I _____, certify that I am the parent/legal guardian of _____, who is _____ years of age as of today. I have completed the Intake Form for the above-mentioned minor and have informed the therapist of all relevant medical history and concerns. I understand the scope of massage therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms.

I give permission for my child's health information to be shared between each of my Chesapeake Holistic practitioners.

Signature: _____

Date: _____