

Infrared Sauna Release Waiver

Name: _____ Phone: (____) _____
Address: _____ Cell: (____) _____
City: _____ State: _____ Zip: _____ Work: (____) _____
Email: _____ DOB: mm/dd/yy ____/____/_____
Emergency Contact: _____ Phone# (____) _____

Please note: the following listed conditions are **CONTRAINDICATIONS** for the use of the Infrared Sauna.

Please indicate if any of the following apply to you:

- | | | |
|---|-----|----|
| 1. Do you have uncontrolled high blood pressure? | Yes | No |
| 2. Do you suffer from Congestive Heart Failure? | Yes | No |
| 3. Are you presently intoxicated with alcohol? | Yes | No |
| 4. Do you suffer from Parkinson's or Multiple Sclerosis? | Yes | No |
| 5. Do you suffer from a Central Nervous System Tumor or Diabetic Neuropathy? | Yes | No |
| 6. Are you pregnant? | Yes | No |
| 7. Do you have a fever? | Yes | No |
| 8. Have you had a recent joint injury (past 48 hours) that is still hot and swollen? | Yes | No |
| 9. Do you have recent wounds from an operation or surgery? | Yes | No |
| 10. Do you have a Pacemaker or defibrillator? | Yes | No |
| 11. Are you taking medications whose levels should not change
(Insulin, seizure, or heart medications) | Yes | No |

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, YOU MUST GET A RELEASE FROM YOUR PHYSICIAN BEFORE USING THE INFRARED SAUNA.

Please indicate if any of the following apply to you:

- | | | |
|---|-----|----|
| 1. Are you currently taking diuretics, barbiturates, beta- blockers or anti-histamines? | Yes | No |
| 2. Are you under the age of 16 or over the age 65? | Yes | No |
| 3. Are you currently having a heavy menstrual period? | Yes | No |
| 4. Do you have a metal pin, rod, artificial joint or any other surgical implants? | Yes | No |
| 5. Do you have a hard time breaking a sweat? | Yes | No |

IF YOU ANSWERED YES TO ANY OF THE ABOVE, YOU NEED TO BE CAUTIOUS. PLEASE SLIGHTLY OPEN THE DOOR OF THE SAUNA TO ALLOW COOL AIR TO COME IN IF YOU ARE TOO HOT. WE WILL SET YOUR FIRST SESSION AT A LOWER TEMPERATURE.

FOR SERIOUS HEALTH CONCERNS PLEASE ASK YOUR MEDICAL PROVIDOR.

DISCLAIMER/WAIVER

I, the undersigned consent to use the Infrared Sauna. I understand that use of the sauna is not intended to take place of medical care or medications. I clearly confirm that I do not have any contraindications listed above. I understand that I can discontinue using the sauna at any time. I understand that I take full responsibility for my own health and wellbeing.

I agree to disclose my health information if my medical health history should change at any time during the period I am using the sauna.

I have read the above disclaimer (including cautions and contraindications for the use of the Infrared Sauna) and I agree that I am not currently suffering with any of the above -mentioned contraindications. I have read the Guidelines for Using the Sauna and I have read the Sauna Policies. I have been given the opportunity to ask questions regarding any of the content. By signing below I agree to release Lipton Natural Health Improvement Center and any of its members from any liability in connection with the use of the sauna.

Step out of the infrared sauna immediately if you experience dizziness or are sleepy. In any rare event, you experience pain and or discomfort, immediately discontinue sauna use.

Client Name _____

Signature _____

Date _____