

BABY REFLEX CONSENT FORMS – BABY & PARENT



Please complete this consent form for PARENT to receive reflexology as a treatment or whilst practicing Baby Reflex techniques and return to your Baby Reflex practitioner.

How did you hear about Baby Reflex?	
Would you like to sign up to my newsletter? YES/ NO (if yes, please supply email address below)	
Your personal information will only be used for marketing communications relating to my business, which I think may be of interest to you. I do not share, or sell, or disclose personal data with third parties (except as set out within my Privacy Policy , which can be viewed on my website). You can update your subscription preferences anytime on my website.	
Name of parent:	Name of baby:
Full address:	Home number: Mobile:
Email:	
Date of birth/...../.....	GP Name and Tel:
Are you currently receiving any prescribed, over-the-counter medication or under any medical supervision?	(please circle): YES / NO Details....
Please describe your current health:	
Other comments:	
I declare the above statements to be true, to the best of my knowledge. I also confirm that I have / or will read and understood the "Guidelines for Reflexology", "After-care for Reflexology" and "Cautions" as provided by my Reflexologist. I understand that this treatment does not / will not diagnose or cure but promotes the mental and physical conditions necessary to gain positive health and help prevent ill health, nor does it replace the medical advice of my GP. I agree that I will not change or alter any medication without prior consent from my GP and if I suspect illness of any kind I will contact my GP. Whilst I understand that my personal details will be held in confidence, I give my permission that in the case of a medical emergency, my personal details be passed onto a medical professional in order to assist with any medical situation that may arise.	
Signature:	Date:

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Please complete this consent form for BABY to receive reflexology as a treatment or whilst practicing Baby Reflex techniques and return to your Baby Reflex practitioner.

Name of baby:	Full name of parent:
Full address:	Home telephone number of parent: Mobile telephone of parent:
Email of parent:	
Baby date of birth/...../..... Current age:	Child's GP Name and Tel:
Is baby currently receiving any prescribed, over-the-counter medication or under any medical supervision?	(please circle): YES / NO Details....
Please describe baby's current health:	
Other comments:	
I declare the above statements to be true, to the best of my knowledge, and that I will personally be responsible for the giving of Baby Reflex only to my baby. I also confirm that I have / or will read and understood the "Guidelines for using Baby Reflex" and "Cautions" as provided by my Baby Reflex practitioner. I understand that this treatment does not / will not diagnose or cure but promotes the mental and physical conditions necessary to gain positive health and help prevent ill health, nor does it replace the medical advice of my GP. I agree that I will not change or alter any medication without prior consent from my GP and if I suspect illness of any kind I will contact my GP. Whilst I understand that my personal details will be held in confidence, I give my permission that in the case of a medical emergency, my personal details be passed onto a medical professional in order to assist with any medical situation that may arise.	
Parents signature:	Date: