Massage Consent Form

I ____________________________________ consent to receive Massage Comfort Touch.
PRINT NAME

Please indicate if any of the following medical conditions apply to you:

- ☐ Low blood cell count
- ☐ Presence or potential for a blood clot
- ☐ Lymph nodes biopsied, in field of radiation or removed during surgery

I confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to this service. I understand that it is my responsibility to consult my physician about any contraindications to my services that might be indicated by my response to the previous questions. I release the Program Therapist, Host Facility, and its management, employees, contractors and volunteers from liability for the results of service that are related to any health conditions indicated on this questionnaire. I further release the Program Therapist and Host Facility from the result of service given based upon any incorrect or incomplete information given by me. I acknowledge, accept and understand all of the above.

____________________	____________________	____________________
SIGNATURE	DATE	LOCATION

____________________	____________________
WITNESS	DATE

If you would like a copy of this Consent Form, please ask.