

LaCURA Salt Spa Consent Form

Client Name: _____ Male__ Female__ Today's Date: _____

Birthdate (mm/dd/yy): _____ Parent's Name (if Client under Age 13): _____

Best Phone #: (_____) _____ - _____ Is this a cell? YES NO

Address:

Street

City

State

Zip

Email: _____

Emergency Contact: Name & Number _____

How did you hear about us? Please check one. Magazine/ Newspaper Facebook Instagram

A Friend? Whom may we thank? _____ Other: _____

Have you experienced a salt therapy before? YES NO How recently? _____ Where? _____

Were you referred by a Doctor? YES NO If yes, doctor's name: _____

Have you had a fever in the last 24 hrs? YES NO Are you currently suffering a cold/flu/bronchitis? YES NO

Are you experiencing respiratory issues? YES NO Are you a smoker? YES NO When did you quit? _____

Respiratory history (check all that apply):

- Allergies (seasonal, environmental) Please list: _____
- Asthma Chronic sinus infections
- COPD (Chronic Obstructive Pulmonary Disease) Chronic nose and throat problems
- Cystic Fibrosis Other: _____

Current Reason for Salt Room visit? (check all that apply): Eczema Psoriasis Emphysema
 Prevention of Cold, Flu, Bronchitis, Pneumonia Recovery from Cold, Flu, Bronchitis, Pneumonia
 Sinus Issues Immune System Support Optimize breathing for athletic activity Optimize breathing for singing or playing wind instruments
 Snoring Offset influence of air pollution Offset influence of electronic pollution General Respiratory Hygiene Relaxation and Stress Relief
 Other: _____

Inform and Consent for Salt Therapy. By initialing below, I confirm that I DO NOT have any of the following:

Acute state of respiratory diseases	Cardiac Insufficiency	Intoxication
COPD in 3rd stage	Uncontrolled High Blood Pressure	Bleeding
Hypertension in II B stage	Blood Spitting	Any and all internal diseases in acute stage

Any other medical conditions we should be aware of? _____

- Please see reverse side for additional information and to sign and date. -

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Severe Allergy, Asthma and COPD Clients If you suffer from severe allergy, asthma or COPD you may want to consider a gradual introduction into Salt Therapy. It is important to set your own pace, if at any time during your 1st session you feel uncomfortable, you are welcome to step out and leave after 10 to 15 minutes and we will be happy to book you another appointment.

*****Infrared Sauna Precautions and Warnings:** The use of drugs or alcohol prior to or during the sauna session may lead to dizziness or unconsciousness. Please contact and consult your physician if you are in doubt of your ability to use the sauna for health reasons. No clients under the age of 16 are permitted in the sauna unless accompanied by a supervising adult. Please discontinue the use of the sauna if you feel light-headed, dizzy or heat exhausted. Sauna sessions should be limited to a maximum of 45 minutes. It is advised to drink plenty of water before and after your sauna session. Clients using any medications must consult a physician prior to the use of the infrared sauna.

Pregnant women SHOULD NOT use the infrared sauna. Clients with a medical history of circulatory system problems should consult a physician prior to using the sauna. Clients with a pacemaker or defibrillator, or other metal implants MUST NOT use the sauna due to magnets used in the construction of the sauna.

Release; Assumption of Risk; Consent to Participation: Salt therapy and infrared saunas are not intended to diagnose, treat, cure, mitigate, or prevent any disease. I understand that it is my responsibility to consult my primary care physician or appropriate, licensed health care practitioner for all my health concerns. I understand that no representations, claims or guarantees are being made as to any medical therapeutic benefit. I understand the potential benefits, risks, consequences of salt therapy and infrared sauna use. I give my consent to participate in salt therapy and/or infrared sauna entirely at my own risk. I am satisfied with and understand the information which has been provided, and I acknowledge that St Augustine Salt Room & Integrative Health, LLC, dba LaCURA Salt Spa, takes no responsibility for customers choosing to treat themselves by means of salt therapy or infrared sauna. Further, I understand that if I choose to take an electronic device into the salt room or infrared sauna, LaCURA Salt Spa cannot be held responsible for any damage that the salt or heat may cause to the electronic device.

For good and valuable consideration, the receipt of which is hereby acknowledged, I hereby release, indemnify, defend, protect, and hold harmless LaCURA Salt Spa and all its employees, independent contractors, shareholders, officers, members, agents, and affiliates (collectively, the "Released Parties") from any and all claims I may have against them relating to my participation in salt therapy. I knowingly, voluntarily, and expressly assume all risk of participation in salt therapy and agree not to bring any legal claim against any of the Released Parties based on such participation.

I certify that I have read the foregoing, discussed the issues noted above, had opportunities to ask questions, and agree to and accept all the terms above.

Client Name (print): _____ Date: _____

Signature: _____

(If signing for a child, please indicate your name and relationship to the client)

Name: _____ Relationship: _____

LaCURA Staff Witness: _____ *Date:* _____