**Elements Therapeutic Massage**

**CONSENT TO TREAT A Prenatal Client**

By signing below, I authorize the licensed massage therapy staff at Elements to administer massage therapy services to me during my pregnancy. I understand that Elements staff strongly encourage me to communicate with my physician about the potential benefits and risks of prenatal massage as relevant to my specific case.

* I am supplying a physician’s note that states I may receive massage during the

(First / second / third) trimester(s) of my pregnancy, and any parameters that apply.

* I have communicated with my physician about the potential benefits and risks of receiving prenatal massage. Listed below are concerns my physician has communicated to me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I waive the recommended opportunity to bring in a note of prenatal massage consent from my physician. I understand I cannot receive massage services from Elements staff during my first trimester of pregnancy without a note from my physician.

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to contact your physician in case of emergency? Yes No

Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I am this many weeks along today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_ (day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (month) \_\_\_\_\_\_\_\_\_\_\_\_(year)

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_