



STUDENT INFORMATION & WAIVER FORM

Name: _____ Birthdate _____

Address: _____

Phone Numbers: _____

Email: (If are not currently receiving info from us, but would like to, we'll add you to the list. *We DO NOT share your information with anyone or organization.* _____)

Are you currently under doctor's care or taking medication for any ongoing health concern? Please specify.

Have you ever been diagnosed with or suffer from any of the following conditions: Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Auto Immune Condition | <input type="checkbox"/> Other |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Accidents/Injuries |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Colitis | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Accident Injury |

Please add any relevant details; (i.e. treatments, medications, dates of injuries or surgeries)

Are you pregnant? If yes, have you received clearance from your doctor to participate in Yoga classes? Please provide due date.

Do you have limited mobility or chronic discomfort in any part of your body? Please specify.

What types of exercise do you participate in? _____

Do you have previous experience with Yoga? _____

What are you hoping to gain as a result of Yoga practice? _____

How did you hear about us? _____

While the benefits of Yoga are varied and wonderful, YOU must learn to listen to and honor your own body and never extend beyond what is comfortable for you.

Waiver of Liability

I agree to take full responsibility for not exceeding my limits in classes and for any injury or discomfort I may experience as a result of practice. I accept that it is my responsibility to ascertain if there are any medical reasons why I should not practice Yoga or other types of movement. I understand that I may injure myself during practice and hereby waive any and all claim I might have at any time for injuries of any sort against Moving Mantra Yoga, Cyndi Bulka Yoga, LLC, any teachers at the studio, and the owners of any properties. I, my legal heirs or representatives forever release, waive, discharge and covenant not to sue the above mentioned parties for any injury or death caused by negligence or other acts. I have read and fully understand the above.

Signature _____ Date _____