

## Medical Consent Form

Massage therapy for a child is not intended to replace other forms of healthcare. Used as a form of adjunctive healthcare, potential benefits for the child include:

|  |  |  |
| --- | --- | --- |
| Skeletal:  - Aids in supporting good posture and balance  - Reduces muscle tension that could lead to potential medical problems  - Increases nutrient flow to bones  Circulatory:  - Stimulates blood and lymph circulation  - Helps strengthen the immune system  - Releases toxins held in the body | Digestive:  - May relieve constipation  - May relieve gas  - Reduces water retention  Cleans the blood by toning the kidneys  Muscular:  - Relieves muscle tension and spasm  - Aids in removal of lactic acid & carbonic acid  - Increases the flow of blood and nutrients to muscles  - Can increase or decrease muscle tone depending upon amount of pressure  - Can reduce or increase joint mobility depending upon amount of pressure | Respiratory:  - Improves breathing patterns  - Helps reduce respiratory problems  - Relieves tension in the chest allowing the lungs to expand more fully  Nervous:  - Relaxes and calms  - Improves sleep patterns  - Raises endorphin levels, promoting healing  - Provides a safe and easy release from frustration and hyperactive behavior  - The Vagus Nerve is stimulated influencing food absorption hormones (Insulin & Glycogen) |

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_  
Caregiver’s Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Pgr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My healthcare provider is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contraindications for Pediatric Massage include:**

* Fever/Temperature
* Acute infection, staph infection, illness or disease
* Skin disorder/condition which may be contagious or cause inflammation (fungus, rashes, herpes)
* Open sores, wounds or lesions
* Recent immunization/vaccination (wait 48 – 72 hours)
* Life threatening medical condition
* Unhealed umbilical cord (tummy massage contraindicated)
* Swollen lymph nodes
* Blood clots or a blood condition
* Diarrhea or other sickness
* Inflammation
* High Blood Pressure
* Hernia
* Osteoporosis
* Varicose Veins
* Broken Bones
* Deep Vein Thrombosis
* Pain
* Lability
* Thrombocytopenia

**Common Precautions for Pediatric Massage include:**

* Apnea
* Bradycardia
* Tachycardia
* Abdominal Distention
* Gastrointestinal or Jejunostomy feeding tubes
* Hydrocephalus
* Inflammations
* Edema
* Dysplasia
* Hemophilia
* Jaundice
* Recent Surgery
* HIV/AIDS
* Tumors
* Cancer
* Seizure Disorders
* Agitation
* Impulsivity

Please indicate any of the high risk factors, complications that I should be aware of:

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

Is there other relevant information about the pregnancy, child birth, about you or the child, that I should know?

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

---------------------------------------------------------------------------------------------------------------------

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that my child will be participating in pediatric massage therapy as a form of adjunct health care. I have noted above all complications, risks, or conditions my child has experienced AND I have obtained my child’s healthcare providers release. I understand that my child will receive pediatric massage therapy as a form of adjunctive health care only and that it is not a substitute for other healthcare provided by a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioner from any claims, liability, demands and causes of action from my and my child’s participation in this therapy.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner’s Contact Information:

Bailey Savannah Dull, LMT #11479, CPMT, CTRS

Pediatric Massage of the Upstate

864-810-0067

bailey@pediatricmassageupstate.com