



Name		DOB	
Address		Phone	
Email		Emergency Contact	

**FORMAL WRITTEN CONSENT BY PARENT OR LEGAL GUARDIAN FOR MINOR CHILD TO USE THE WHOLE BODY CRYOTHERAPY CHAMBER.**

I have completely read and understand each and every provision of the Contraindications/Waiver/Hold Harmless /Indemnification conditions.

I hereby give my full Parental or Guardian consent and permission for my minor child (Print Child's Name) \_\_\_\_\_ to participate in Whole Body Cryotherapy sessions.

I acknowledge, understand and represent that my minor child has attained the legal age of eleven (11) years, and that all minors between the ages of eleven (11) and thirteen (13) years must be accompanied in the chamber by a parent or legal Guardian.

I understand that the cryotherapy treatment consists of spending a short period of time in an extremely cold environment and

that I/my child are free to exit the chamber at any time we choose if we feel at all uncomfortable. I further understand that

because of the extreme cold and the limited size of the Cryotherapy Chamber, I/My child may experience symptoms of

Claustrophobia, Hyperventilation, skin irritation (including frostbite), and cold burn.

I/We acknowledge that participation in this process is completely voluntary and at My/Our request.

I have read this form and the process has been explained thoroughly to me. I have been given the opportunity to ask questions

and my questions have been answered to my satisfaction.

Having been fully informed, I hereby give my Parental or Guardian Consent for my minor child

\_\_\_\_\_ to participate in the cold therapy procedure either with my accompaniment (if between the

ages of eleven (11) and thirteen (13), or on his/her own, if between the ages of fourteen (14) and seventeen (17



Question	Yes	No
<b>Major Cardiovascular/Pulmonary Risk Factors</b>		
Have you had a Heart Attack within the previous 6 months?		
Do you have a Pacemaker?		
Have you had a Heart Bypass or Valvular Disease within the previous 6 months?		
Do you have Congestive Heart Failure?		
Do you have Chronic Obstructive Pulmonary Disease (COPD)?		
Do you have peripheral arterial occlusive disease?		
<b>Circulatory Risk Factors</b>		
Circulatory Risk Factors Do you have any major circulatory dysfunction?		
Do you have any known cold allergies or have hypersensitivity to cold?		
Do you have any blood disorders?		
Do you have Intrathecal Pump Implant (pain pump)?		
Do you have Deep Vein Thrombosis (DVT)?		
<b>Other Risk Factors</b>		
Do you have any open wounds, sores or healing disorders?		
Are you Pregnant?		
Do you have a history of Seizure Disorders?		
Do you have kidney disease?		
Are you under the influence of drugs or alcohol?		
Hypertension (BP> 180/100)?		
Unstable angina pectoris?		
Symptomatic lung disorders?		
Raynaud's Syndrome?		
Acute kidney and urinary tract diseases?		
Severe Anaemia, infection?		
Any other major disease or diagnosis? Please state		



### **Physical Capability Requirements**

Participation in a Whole Body Cryotherapy (WBC) session involves exposure to extreme cold temperature for a short period of time (not to exceed three and one-half (3:30) minutes per session). During the WBC session, the chamber technician will be present during the entire duration of your session. Additionally, you are free to walk out of the chamber at any time. The cold therapy session is followed by a five (5) to ten (10) minute period of light to moderate exercise.

### **LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT**

In consideration of being permitted by US Cryotherapy to participate in their services, I hereby waive any and all claims and damages for personal injury or death which may occur as a result of my participation. I understand and agree that:

1. This release is intended to discharge in advance US Cryotherapy, its officers, officials, employees, agents and volunteers from and against all liability arising out of or connected in any way with my participation in these activities;
2. Participation may involve risk of serious injury, illness, disability or death and may result not only as a result of my actions, negligence or inaction, but also from the action, negligence or inaction of others, including their owners, official employees, or volunteers and may result from the conditions of the facilities, equipment, or areas where such activities are being conducted;
3. Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate;
4. I will indemnify and hold harmless US Cryotherapy, its owners, officers, officials, employees and volunteers from any loss, liability, damage, cost or expense, including litigation of any form, arising out of or connected in any manner with my participation in such activities;
5. I am in good health and have no physical condition expressed in the 'Contraindications' or otherwise which would preclude me from safely participating in such activities;
6. I understand and agree that this release is intended to be as broad and inclusive as permitted under the law of the State in which it is executed and that if any portion of this Hold Harmless, Release and Indemnification Agreement should be determined to be invalid, it is my intent that the remaining provisions shall continue in full force and effect.

**Name of minor obtaining Parental or Guardian consent:** \_\_\_\_\_

**Parent / Legal Guardian's name (printed) and signature** \_\_\_\_\_

**Date** \_\_\_\_\_