



# Yoga Strong Foundation Event Registration

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell.Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity (optional): \_\_\_\_\_

Are you a member of the US Armed Forces? (circle one) Yes No If so, for how long? \_\_\_\_\_

How did you hear about the Yoga Strong Foundation Event? \_\_\_\_\_

**Please complete the following questions carefully. Yoga may be contraindicated if you have specific medical conditions/symptoms.**

My overall state of health is \_\_\_\_\_

Are you currently experiencing: (please check all that apply and comment where appropriate)

- |   |  |                                       |                                       |
|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Diabetes/Hypoglycemia             | <input type="checkbox"/> Scoliosis    | <input type="checkbox"/> Anxiety      |
| <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Glaucoma or Detached Retina       | <input type="checkbox"/> Migraines    | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Muscle cramps        | <input type="checkbox"/> Joint injuries, limitations, pain | <input type="checkbox"/> Asthma       | <input type="checkbox"/> PTSD         |
| <input type="checkbox"/> Pain in neck or back | <input type="checkbox"/> Disc problems in neck or back     | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Sciatic or radiating pain         | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis |

Please provide details on any item checked above or list any other significant medical condition you may have. (Use back of page if more space is needed.)

\_\_\_\_\_

Please list medications you are taking and for what reason: \_\_\_\_\_

\_\_\_\_\_

Please list other medical issues, major operations, accidents, or injuries (car accidents, surgery, etc): \_\_\_\_\_

\_\_\_\_\_

By signing below I understand and agree:

- 1.) That I take **full responsibility** for my body and my movements during this event, and I will not hold my Yoga teacher or Yoga Strong Foundation liable for personal injury arising from my participation in class.
- 2.) It is my responsibility to remind the Yoga teacher about my limitations and medical issues at the start of EVERY class.
- 3.) If I experience any pain or discomfort at any time during a class session, I will immediately ease out of the pose and inform the teacher so that the pose can be modified to meet my body's needs and limitations.

I am over the age of 18. If you under the age of 18, you will need a guardian to co-sign.

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

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

Name of Event:  
Date of Event