CancerCare NORTHWEST™

Physician Release:

I hereby release _____, who is currently in my care, to participate in a group yoga exercise class _____ times per week. If any issues or concerns arise while participating in the yoga class, patient has been advised to call in and speak to a nurse.

Physician Signature _____ Date ____/____/_____

Patient Release:

I, _____, have voluntarily enrolled in a yoga class offered at Cancer Care Northwest. I understand that yoga includes physical movement as well as an opportunity for relaxation, stress re-education , and relief of muscular tension. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, discontinue the activity, and ask for support from the instructor. I will continue to breathe smoothly. I assume full responsibility for any and all damages which may incur through participation.

Yoga is not a substitute for medical attention, examination, diagnosis, or treatment. Yoga is not recommended and is not safe under certain medical conditions. By signing, I affirm that a licensed physician has verified my health and physical condition to be stable enough to participate in such a fitness program. In addition, I will make the instructor aware of any medical conditions or physical limitations before class. If I am pregnant, become pregnant, or I am post-natal or post-surgical, my signature verifies that I have my physician's approval to participate. I also affirm that I alone am responsible to decide whether to practice yoga and participation is at my own risk. I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against Cancer Care Northwest and its instructors.

I have read and fully understand and agree to the above terms of this Liability Waiver Agreement. I am signing this agreement voluntarily and recognize that my signature serves as complete and unconditional release of all liability to the greatest extent allowed by law in the State of Washington.

Patient Signature _____ Date ____/____/_____

Date of Birth ____/____/_____

Emergency Contact Name/Phone _____

For Internal Use:

Please route completed form to Elana Stahl via inter-office mail OR Fax to #509-252-9443.