Elk Grove Healing Massage

9132 Elk Grove Blvd, Elk Grove, CA 95624 | 916-430-9276 | www.eghealingmassage.com

MINOR CLIENT LIABILITY RELEASE & PARENTAL CONSENT

Minor's Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Relationship to Minor:** _____

Phone: _____ **Date:** _____

PARENTAL AUTHORIZATION

I am the parent or legal guardian of the above-named minor and hereby give my full permission for my child to receive massage therapy services at Elk Grove Healing Massage. I confirm that I have the legal authority to consent to this treatment on the minor's behalf.

PRESENCE DURING TREATMENT

I understand that a parent or legal guardian is required to remain on the premises, and in the treatment room, for the entire duration of the minor's massage session, unless otherwise agreed to in writing with the therapist.

HEALTH DISCLOSURE

I confirm that I have truthfully disclosed all known physical conditions, injuries, allergies, medications, and health concerns relevant to my child's treatment, and I agree to inform the therapist of any changes at future visits.

ASSUMPTION OF RISK & RELEASE OF LIABILITY

I understand massage therapy may occasionally cause temporary soreness, bruising, or discomfort, and I voluntarily accept these risks on behalf of my child. In consideration of services provided, I release and hold harmless Elk Grove Healing Massage, its owners, therapists, and staff from any claims, liability, or damages arising from my child's treatment, except in cases of gross negligence or willful misconduct.

CLIENT CONDUCT & CONFIDENTIALITY

Services provided are strictly therapeutic and non-sexual in nature. All personal and health information provided is kept confidential in accordance with applicable privacy laws.

CONSENT

I have read and understood the above, had the opportunity to ask questions, and voluntarily consent to my child receiving massage therapy services at Elk Grove Healing Massage under the terms outlined here.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____

Therapist Signature: _____ **Date:** _____