

Health Registration Form



Please complete this form for the benefit of yourself and your yoga teacher.

Firstname: Surname:

Address:

.....Postcode:

Email:Telephone:

Please answer all the questions below

Date of first yoga class:

Have you any previous experience of yoga? YES NO
if YES, how long for and what school of yoga?

Do you have any illnesses, medical conditions past or present,
injuries or any disabilities which may affect your yoga practice? If YES please state YES NO

Do you smoke? YES NO

Are you taking any form of medication that may have some bearing on your yoga practice? YES NO
if YES please seek advice from your doctor or other health professional before starting to practice yoga.

What would you identify as the major source of stress in your life at the moment?

What do you usually do to relieve stress?

Are you in agreement for the information on this form to be shared with a supply teacher? YES NO

I give my consent to any use of photographs in class situations to be used for publishing YES NO

I understand that I participate in all yoga classes entirely at my own risk and any loss, damage, injury or any other mishap will not be the responsibility of the class organiser or teacher. I understand that refunds will be only be given if the course / class I want is booked. Policy Santoshayoga

Signed: Date:

Thankyou for completing this form

The information supplied on this form is in the strictest of confidence and subject to the constraints of the Data Protection Act 1998