Yoga Balance

REGISTRATION & HEALTH INFORMATION

Name: _____

Address: _____ City_____ Zip Code_____

Phone #: _____ **Date of Birth:** _____

Email: _____ **Cell Phone #:** _____

Emergency Contact and Phone #: _____

Please describe your yoga experience, if any: _____

_____

Health Questions

Please list any prescription medication(s) that you take and for what condition:

_____

_____

Please list all injuries and illnesses (past and present): _____

_____

_____

Please list any other health conditions you have that could affect your yoga practice, including, but not limited to: high blood pressure, asthma, heart condition, diabetes, pregnancy: _____

_____

_____

Signature of participant: _____ **Date:** _____

Printed Name: _____

If the participant is **under** the age of **18**,

Signature of **Parent/Guardian:** _____

Print Name: _____ **Date:** _____