Release Form

Date:____
Name:____
Address:____
City:_____________________________ Zip:__________________
Home Phone:______________________ Cell Phone:____________
Email Address:_____________________ Class Choice:__________

Release:
I, the undersigned, hereby waive, release, and forever discharge Arlene Lucas & Divine Yoga, her employees, representatives, agents and assigns, from and against any and all damages arising directly or indirectly from my participation in any activities administered, demonstrated or taught by Arlene Lucas & Divine Yoga, or her employees and representatives . I have had the therapy that I am about to undergo adequately explained to me; all of my questions have been answered. I fully understand that any activity related to any form of body work and yoga is a potentially dangerous activity. The oral and written presentations at this program are the unique intellectual property of Divine Yoga and are protected by copyright. I acknowledge that I am in good physical health and that I have previously consulted with a licensed physician to approve my participation in this activity, or that I have voluntarily chosen not to seek prior professional medical advice. I acknowledge and agree that any information communicated to me by Arlene Lucas & Divine Yoga, her employees
and representatives, does not constitute and is not a substitute for professional medical advice.

I am aware that my photograph may be taken and posted on the Divine Yoga website.

I have read, understood and hereby agree to provide this release as of the date and year written below.
Signature:___________________________ Date:_________________
If Under 18 years of age:
As Legal Guardian of: ______________________________________
We consent to the above conditions.

If you have any kind of pre-existing conditions which may affect your ability to participate in yoga, please let me know and consult a health care practitioner to approve your participation.

Possible ailments: (please specify)

1. Bad Back
2. Asthma
3. Sciatica
4. Stress
5. Low flexibility
6. Chronic illness
7. Migraine
8. Other:____

I am aware of the expiration dates for the different class series and understand that there are no extensions unless I can prove that there is medical reason for requesting one.

Signature:_______________________________ Date:_______________________