Attentive Touch

Your natural alternative to improved mental and physical health.

Dawn M. Bell
New Jersey Licensed Massage Therapist
Certified Pediatric Massage Therapist
Hackettstown, NJ
dbell@attentivetouch.com Phone: 908-878-9113 www.attentivetouch.com

PEDIATRIC MASSAGE - Medical Consent Form (18YRS AND YOUNGER) Date: ___________________

Child's Name: ____ M ( ) F ( ) Date of Birth: ______________

Parent's Name(S): ____

Referred By:____

My Healthcare Provider Is:____

Contraindications for Pediatric Massage Include:

- fever/temperature
-life threatening medical condition
- swollen lymph nodes
- deep vein thrombosis
- blood clots or a blood condition
- high blood pressure
- inflammation
- hernia
- pain
- recent immunization/vaccination (wait 48-72 hours)
- acute infection, staph infection, illness or disease
- open sores, wounds, or lesions
- lability
- life threatening medical condition
- broken bones
- diarrhea or other sickness
- varicose veins
- osteoporosis
- unhealed umbilical cord (tummy massage contraindicated)
- skin disorder/condition which may be contagious or cause inflammation fungus, rashes, herpes)

Common Precautions for Pediatric Massage Include:

- apnea
- inflammations
- jaundice
-cancer
- hydrocephalus
- bradycardia
- edema
- HIV/AIDS
- agitation
- gastrointestinal or feeding tubes
- tachycardia
- dysplasia
- tumors
- impulsivity
- abdominal distention
- hemophelia
- seizure disorders
- recent surgery

Please check any of the contraindications and/or precautions that I should be aware of and describe below.

____
____
____

If massage if to be used in conjunction with other health care:

I, ____, understand that my child will be participating in pediatric massage therapy as a form of adjunct health care. I have noted above all complications, risks, or conditions my child has experienced AND I have obtained my child's healthcare providers release. I understand that my child will receive pediatric massage therapy as a form of adjunctive health care only and that it is not a substitute for other healthcare provided by a medical doctor or other licensed provider.
I hereby release and hold harmless and defend Wendy Rolfe-Cook from any claims, liability, demands and causes from action from my and my child's participation in this therapy.

Signature: ____ Date: _____________ Print Name: ____

Dawn M. Bell (Practitioner): ____ Date: ____