USCryotherapy
FASTER RECOVERY ▪ BETTER HEALTH

FORMAL WRITTEN CONSENT BY PARENT OR LEGAL GUARDIAN

FOR MINOR CHILD TO USE THE WHOLE BODY CRYOTHERAPY CHAMBER

Minor's Name: _____ **Birthdate:** _____ **Gender:** _____

Address: _____

Phone: _____ **Cell Phone:** _____

E-mail: _____

EMERGENCY CONTACT

Contact Name: _____ **Relationship:** _____

Contact Phone: _____

- I have completely read and understand each and every provision of the Contraindications/Waiver/Hold Harmless/ Indemnification conditions.
- I hereby give my full Parental or Guardian consent and permission for my minor child (Print Child's Name) _____ to participate in Whole Body Cryotherapy sessions.
- I acknowledge, understand and represent that my minor child has attained the legal age of eleven (11) years, and that all minors between the ages of eleven (11) and thirteen (13) years must be accompanied in the chamber by a parent or legal Guardian.
- I understand that the cryotherapy treatment consists of spending a short period of time in an extremely cold environment and that I/my child are free to exit the chamber at any time we choose if we feel at all uncomfortable.
- I further understand that because of the extreme cold and the limited size of the Cryotherapy Chamber, I/My child may experience symptoms of Claustrophobia, Hyperventilation, skin irritation (including frostbite), and cold burn.
- I/We acknowledge that participation in this process is completely voluntary and at My/Our request. I have read this form and the process has been explained thoroughly to me. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

Having been fully informed, I hereby give my Parental or Guardian Consent for my minor child _____ to participate in the cold therapy procedure either with my accompaniment if between the ages of eleven (11) and thirteen (13), or on his/her own, if between the ages of fourteen (14) and seventeen (17).

Question	YES	NO
Absolute Contraindications		
Have you ever had a heart attack within the previous 6 months?		
Do you have a pacemaker?		
Have you had a heart bypass or valvular disease within the previous 6 months?		
Do you have congestive heart failure?		

Do you have chronic obstructive pulmonary disease (COPD)?		
Do you have an intrathecal pain pump or any electro stimulation implant device? (i.e spinal stimulator implant)		
Do you have any chronic or acute kidney conditions?		
Are you pregnant?		
Relative Contraindications		
Do you have a history of seizure disorders?		
Do you have cold allergies with known skin reactions to cold?		
Do you have any blood disorders (such as hemophilia or blood clots)?		
Do you have any major circulatory dysfunction (such as deep vein thrombosis)?		
Do you have Heart Arrhythmia or Atrial Fibrillation?		
Do you have an Active Cancer diagnosis?		
Other Risk Factors		
Do you have any open wounds, sores, or healing disorders?		
Are you under the influence of drugs or alcohol?		

PHYSICAL CAPABILITY REQUIREMENTS

Participation in a Whole Body Cryotherapy (WBC) session involves exposure to extreme cold temperature for a short period of time (not to exceed three and one-half (3:30) minutes per session). During the WBC session, the chamber technician will be present during the entire duration of your session. Additionally, you are free to walk out of the chamber at any time. The cold therapy session is followed by a five (5) to ten (10) minute period of light to moderate exercise.

LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT

In consideration of being permitted by US Cryotherapy to participate in their services, I hereby waive any and all claims and damages for personal injury or death which may occur as a result of my participation. I understand and agree that:

1. This release is intended to discharge in advance US Cryotherapy, its officers, officials, employees, agents and volunteers from and against all liability arising out of or connected in any way with my participation in these activities;
2. Participation may involve risk of serious injury, illness, disability or death and may result not only as a result of my actions, negligence or inaction, but also from the action, negligence or inaction of others, including their owners, officers officials employees, or volunteers and may result from the conditions of the facilities, equipment, or areas where such activities are being conducted;
3. Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate;
4. I will indemnify and hold harmless US Cryotherapy, its owners, officers, officials, employees and volunteers from any loss, liability, damage, cost or expense, including litigation of any form, arising out of or connected in any manner with my participation in such activities;
5. I am in good health and have no physical condition expressed in the 'Contraindications' or otherwise which would preclude me from safely participating in such activities;
6. I understand and agree that this release is intended to be as broad and inclusive as permitted under the law of the State in which it is executed and that if any portion of this Hold Harmless, Release and Indemnification Agreement should be determined to be invalid, it is my intent that the remaining provisions shall continue in full force and effect.

_____

Name of minor obtaining Parental or Guardian Consent

_____ _____

Parent/Legal Guardian's Name (printed) and signature Date