



AME SPA INFRARED SAUNA RELEASE WAIVER

Name _____ Date _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone (____) _____ (cell) (____) _____
 Emergency Contact _____ Phone # (____) _____

Please note the following listed conditions are considered contraindications for the use of Far Infrared Saunas. Please indicate if any of the following apply to you:

- | | | |
|--|-----|----|
| 1. Do you have uncontrolled high blood pressure? | Yes | No |
| 2. Do you have a Heart condition? | Yes | No |
| 3. Have you consumed alcohol? | Yes | No |
| 4. Do you suffer from Parkinson's, Multiple Sclerosis? | Yes | No |
| 5. Do you suffer from a Central Nervous System Tumor or Diabetic Neuropathy? | Yes | No |
| 6. Are you pregnant? | Yes | No |
| 7. Do you have a fever? | Yes | No |
| 8. Have you had a recent joint injury (past 48 hours) that is still hot and swollen? | Yes | No |
| 9. Do you have recent wounds from an operation or surgery? | Yes | No |
| 10. Do you have a Pacemaker or defibrillator? | Yes | No |

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, YOU MUST GET A RELEASE FROM YOUR PHYSICIAN BEFORE USING INFRARED SAUNA.

Please indicate if any of the following apply to you:

- | | | | | |
|---|-----|----|-----|----|
| 1. Are you currently taking diuretics, beta-blockers or anti-histamines? | Yes | No | Yes | No |
| 2. Are you under the age of 16 or over the age of 65? | | | Yes | No |
| 3. Are you currently having a heavy menstrual period? | | | Yes | No |
| 4. Do you have a metal pin, rod, artificial joint or any other surgical implants? | | | Yes | No |
| 5. Do you have a hard time breaking a sweat? | | | Yes | No |
| 6. Are you wearing jewelry? | | | Yes | No |

IF YOU ANSWERED YES TO ANY OF THE ABOVE, YOU NEED TO BE CAUTIOUS. PLEASE SLIGHTLY LIFT THE DOME OF THE SAUNA TO ALLOW COOL AIR TO COME IN IF YOU ARE TOO HOT. WE MAY SET YOUR FIRST SESSION FOR A SHORTER TIME PERIOD.

DISCLAIMER / WAIVER

I, the undersigned, consent to the Infrared Sauna Treatment. I understand that these procedures are for the purpose of detoxification and are not intended to take place of medical care or medications. I clearly confirm that I do not have any contraindications to the Infrared Sauna Treatments. I understand that I take full responsibility for my own health and well-being

I agree to disclose to AME SALON AND SPA if my medical health history should happen to change during the time period of receiving Far-Infrared Sauna Treatments.

I have read the above disclaimer (including cautions and contraindications for the use of Far-Infrared Sauna) and I agree that I am not currently suffering with any of the above mentioned contraindications. I have read the recommendation sheet AND I have had the opportunity to ask any questions about its content, and by signing below I agree to release AME SALON AND SPA and its members from any liability in connection with the use of the sauna.

Step out of the infrared sauna immediately if you experience dizziness or are sleepy. In the rare event, that you experience pain and / or discomfort, immediately discontinue sauna use.

Client Name _____ **(please print)**

Signature _____ **Date** _____