**New Yoga Student Information Form**

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| Name: |  | | |
| Address: |  | | |
| Postcode: |  | Date of Birth: |  |
| Phone: |  | Mobile: |  |
| Email: |  |
| Occupation |  | | |
| Yoga experience: |  | | |

The information requested below is necessary for us to ensure that we can keep you safe and productive in your yoga practice. It will be stored securely and only shared with the specific teachers taking classes you attend. It is your responsibility to share with us any information which changes or if new conditions occur, prior to practice. It is important in yoga that if you experience pain at any time to listen to your body, which could feel different from day to day, and to ease off carefully and immediately from that pose. For zoom classes it is impossible to watch everyone closely and therefore it is your responsibility to take care of your body. Listen to it's feedback and carefully ease out of any poses which are causing pain in any joint etc. Take care!!

|  |  |
| --- | --- |
| Any current injuries  or surgery including  Joint replacements |  |

Please tick if you have ever experienced any of the following and, if so, please add more information:

|  |  |
| --- | --- |
| To Do High To DoLow Blood Pressure | To Do Anxiety |
| To Do Heart Condition | To Do Stroke |
| To Do Eye Condition (detached retinas etc) | To Do Arthritis |
| To Do Migraine / Headaches | To Do Chest / Lung Condition |
| To Do Hernia | To Do Ear / Balance Condition |
| To Do Neck Pain | To Do Back Pain |
| To Do Vertigo | To Do Hyper Mobility |

I, the undersigned, understand that Yoga is not a substitute for medical attention, diagnosis or treatment. If I have old or current physical issues or injuries, I confirm that I have the approval from my doctor to attend yoga classes. I take full responsibility and accept all liability for my health and safety and understand that injuries can occur while practicing Yoga and that it is impossible for the teacher to be responsible for my health and safety when practicing over zoom or on a recorded playback.

To Do I would like to be able to send you emails, these include cancellation of classes, class timetable changes etc.

**For GDPR, you must tick this box to receive these. You may unsubscribe at any time.**

SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE READ CAREFULLY

* I am not experiencing any symptom of COVID-19 such as a dry cough, shortness of breath or difficulty breathing, fever, sore throat, or new loss of taste or smell. I confirm that I will not attend a class if I have any of these symptoms.
* I have not travelled abroad and should now be in self isolation.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19 in the last 5 days.
* I have not had a positive test for Coronavirus/Covid-19 and not yet cleared as non-contagious by the NHS.
* I will abide by any new COVID restrictions if they are announced.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date