Ottawa Regional Cancer Foundation

Far Infrared Sauna Release Form

The Ottawa Regional Cancer Foundation/Maplesoft Center requires Doctor's consent prior to using the Infrared Sauna. Kindly complete the following detail and return.

Name: _____	Email: _____
Address: _____	Phone: (_____) _____
City: _____	Cell: (_____) _____
Province: _____	Work: (_____) _____
Postal Code: _____	DOB (mm/dd/yy): _____ /_____ /_____
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 suffer from Congestive Heart Failure?	☐ Yes	☐ No
3.	Are you presently intoxicated with increased consumption of 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
11.	Are you currently receiving treatment (i.e. chemotherapy or radiation)?	☐ Yes	☐ No
12.	Have you ever had a seizure?	☐ 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, barbiturates, beta-blockers or anti-histamines?	☐ Yes	☐ No
2.	Are you under the age of 16 or over the age of 65?	☐ Yes	☐ No
3.	Do you have a metal pin, rod, artificial joint or any other surgical implants?	☐ Yes	☐ No
4.	Do you have difficulty sweating?	☐ Yes	☐ No

If you answered yes to any of the above, you need to be cautious. Please slightly open the door of the sauna to allow cool air to come in if you are too hot. We will set your first session at a lower temperature

***Please note that smokers are prohibited in using the infrared sauna.**

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 can discontinue my treatments anytime. I understand I can discontinue my sauna use at anytime.

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.

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

Client Name: _____ _____ Doctor's Name: ___ _____

Signature: _____ _____ Signature: _____ _____

Date: _____