CONSENT FOR TREATMENT OF MINOR

Name of Minor_____

Age_____**DOB** _____/_____/_____

Address _____

I hereby give consent for the above named minor to receive treatment in Craniosacral Therapy and from the therapist at Selah Massage and Bodywork, and will not hold liable the therapist for complications that may arise as a result of the treatment. I understand that Craniosacral Therapy is a soft tissue modality, and that the therapist does not diagnose conditions. Any information shared during a session is for educational purposes only.

Signature of
Parent or Legal Guardian_____

Date _____/_____/_____