RISK ASSESSMENT AND INFORMED CONSENT

		DATE	
NAME			
DATE OF BIRTH		GENDER	
ADDRESS			
EMAIL		CONTACT NO.	
NEXT OF KIN/EMERGENCY CONTACT NAME AND NUMBER			

WHOLE-BODY CRYOTHERAPY CHAMBER

COVID-19 QUESTIONS:

1. Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID – 19 diagnosis in the past 14 days?	**YES/NO**
2. Do you have any of the following: fever or chills, cough, shortness of breath or difficulty breathing, body aches, headache, new loss of taste or smell, sore throat?	**YES/NO**

If you suspect you may be experiencing any of the symptoms above, government guidelines advise you to isolate and consult with your GP. If you suffer from any medical conditions or allergies which could impact your ability to use our facility, please consult with your GP before doing so.

At Nimaya MindStation, we make all reasonable efforts to ensure a comfortable, clean and safe environment for you. To ensure this, please read the following and sign your name to indicate your understanding and agreement.

THIS RISK ASSESSMENT AND WAIVER APPLIES TO THE UPCOMING FLOATATION TANK SESSION AND ALL SUBSEQUENT FLOATATION TANK EXPERIENCES UNDERTAKEN BY THE UNDERSIGNED AT NIMAYA MINDSTATION.

I will **NOT** use the Whole-Body Cryotherapy:

a. with oils or creams on my body;
b. under the influence of drugs or alcohol;
c. if I suffer from fever, unless, in the opinion of my physician, my fever is under medical control so that I am in sufficient safety to use the cryotherapy chamber;
d. if I am epileptic, unless in the opinion of my physician, my epilepsy is under medical control so that I am in sufficient control of my seizures not to endanger myself in the cryotherapy chamber;
e. if I am pregnant;
f. if I am menstruating, without the use of proper feminine products;
g. if I suffer from Hypertension (high blood pressure) (BP> 160/100), unless, in the opinion of my physician, my Hypertension is under medical control so that I am in sufficient safety to use the cryotherapy chamber;
h. if I suffer from diabetes, unless, in the opinion of my physician, my diabetes is under medical control so that I am in sufficient safety to use the cryotherapy chamber;
i. if I suffer or have suffered from chronic heart disease, wear a pacemaker or suffer from any other heart problem unless, in the opinion of my physician, my chronic heart disease, my pacemaker or my heart problem is under medical control so that I am in sufficient safety to use the cryotherapy centre;
j. if I suffer from any mental or physical illness or ailments and whether I am on any medication or getting treatments of any sort, unless, in the opinion of my physician, my illness or ailment is under medical control so that I am in sufficient safety to use the cryotherapy chamber;
k. if I suffer from incontinence, nausea, epilepsy or psychotic attacks;
l. if I have medically been advised not to use a cryotherapy chamber;
m. if I have a history of regular ear infections;
n. if I am injured, have open or bleeding wounds;
o. if I have an acute skin condition unless, in the opinion of my physician, my skin condition is under medical control so that I am in sufficient safety to use the cryotherapy chamber;
p. if I have recently had an operation unless, in the opinion of my physician, my physical and mental condition is under medical control so that I am in sufficient safety to use the cryotherapy chamber;
q. if I have been advised not to use this treatment by my physician;
r. if I suffer from any allergies that would flare up by using this treatment;
s. if I suffer from acute or recent myocardial infarction (heart attack), arrhythmia, symptomatic cardiovascular disease, accident, such as stroke, uncontrolled seizures, symptomatic lung disorders, bleeding disorders, infection, claustrophobia, intolerance to cold, incontinence unless, in the opinion of my physician, the said ailments or conditions are under medical control so that I am in sufficient safety to use the cryotherapy chamber.

1. I confirm that I have read the form carefully and fully understand the above statements.

2. I confirm that the nature of the Whole-Body Cryotherapy experience has been explained to me.

3. I confirm that I understand that the Whole-Body Cryotherapy is not a medical or psychological therapy and is not intended as a treatment or remedy for any condition.

4. I confirm that I have been asked at this time whether I have any unanswered questions and that I will ask any additional questions that may be of concern to me before this and any future use of the Whole-Body Cryotherapy.

5. I hereby confirm that no warranty or guarantee, or other assurance has been made to me covering the results of the Whole-Body Cryotherapy treatment. I have been explained and understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this consent is being given in advance of any administration of the process and is being given by me voluntarily to use the Whole-Body Cryotherapy equipment.

6. I confirm that I am satisfied that the person supervising my Whole-Body Cryotherapy session has the knowledge and training to do so.

7. I confirm that if in future my medical condition should change in any way that I will inform Nimaya MindStation for a reassessment of my eligibility to use Whole-Body Cryotherapy.

8. I hereby agree to indemnify and hold harmless Nimaya Mindstation from any costs related damage or similar related costs that may incur due to the use of the Whole-Body Cryotherapy by me.

9. Upon using Whole-Body Cryotherapy, I absolve Nimaya MindStation and its employees and agents from any and all liability in connection with use thereof whether such loss or damage be direct or indirect.

10. This Agreement shall be construed in accordance with the laws of England and Wales.

I confirm that I am a competent adult of at least 18 years of age and that by signing this form I am fully aware of the risks and hazards connected to the use of the equipment. I am voluntarily participating in the equipment usage. I also hereby agree and understand that I shall have consulted with my own doctor prior to using the Whole-Body Cryotherapy chamber if I am currently taking any medication or under a doctor's care for any reason or if I have or ought to have any reason for consulting my doctor before using the Whole-Body Cryotherapy chamber.

SIGNATURE..... DATE.....

OFFICE USE ONLY	
SUPERVISOR	Check and signature: