NEW YORK INSTITUTE OF MASSAGE, INC.

P.O. Box 645
Buffalo, NY 14231
(716) 633-0355
(716) 633-0213 fax
1-800-884-NYIM (6946)

MEDICAL RELEASE FORM

Please submit this form to your physician and have him/her complete and return to: PO Box 645, Buffalo, NY 14231.

Note: Your application is not complete until we have received this form.

Student Name _____ **Phone Number** ( ) -

Address _____ **Date of Birth** _____

City State Zip _____ **Social Security #** _____

I _____ **authorize my physician to release needed**
PRINT NAME

medical information to the New York Institute of Massage.

_____
SIGNATURE

Dear Physician:

The person listed above is applying to become a student at the New York Institute of Massage. Massage training requires students to be in contact, through touch, with clients and fellow students. Over the 12 or 24-month training period, the student will give and receive massage almost daily. Please verify that this student is free of any infectious diseases, current on MMR immunizations, has no medical / psychological condition, or contraindications, which would prevent him/her from performing or receiving massage and/or bodywork and has no allergies to: rubbing alcohol, lotions, oils or carpeting. Please verify information on the reverse side of this form by your signature and office stamp.

Physician's Name (please print) _____ **Date** _____

Physician's Signature _____ **Address** _____

Phone Number _____ **City State Zip** _____

Physician Comments: _____

_____

_____

TO BE COMPLETED BY APPLICANT:

1. **Have you been diagnosed with a medical/psychological condition? If yes, please explain:**

2. **How long have you had this condition?**_____

3. **Have you had similar conditions in the past? If yes, describe:** _____

_____**4.**

What activities aggravate your condition?_____

_____

5. **Is the condition getting progressively worse? Y N Constant? Y N Sporadic? Y N**

6. **Is the condition interfering with: ☐ work ☐ sleep ☐ daily routine ?**

7. **List surgical operations or significant injuries and dates:** _____

_____

8. **Are you taking prescription medication? Please list:**

_____

_____

9. **Are you pregnant? YES NO MAYBE If yes, how many weeks?**_____

If you are under three (3) months pregnant, you are unable to receive massage till the 4th month.

PLEASE INDICATE WITH A CHECK MARK IN THE BOX TO THE LEFT OF EACH COLUMN, THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD.

☐	Alcoholism	☐	Chronic Fatigue Syndrome	☐	Hernia	☐	Pneumonia
☐	Allergies, Please List: Include Foods	☐	Circulatory Condition	☐	Herpes (1 or 2)	☐	Rheumatoid Arthritis
☐	_____	☐	C.O.P.D.	☐	High Blood Pressure	☐	Scarlet Fever
☐	_____	☐	Diabetes	☐	Influenza	☐	Scoliosis
☐	_____	☐	Eczema	☐	Intestinal Problems	☐	Stroke
☐	Anemia	☐	Emphysema	☐	Low Back Pain	☐	Tuberculosis
☐	Aneurysm	☐	Epilepsy	☐	Mental Illness	☐	Thyroid
☐	Arteriosclerosis	☐	Fibromyalgia	☐	Migraines	☐	Varicose Veins
☐	Arthritis	☐	Goiter	☐	MS	☐	Visual Impairment
☐	Asthma	☐	Gout	☐	Neuralgia	☐	
☐	Cancer	☐	Headaches	☐	Osteoarthritis	☐	
☐	Carpal Tunnel Syndrome	☐	Heart Disease	☐	Osteoporosis	☐	
☐	Cervical (Neck) Pain	☐	Hepatitis	☐	Pleurisy	☐	