

**Lucile Packard
Children's Hospital
AT STANFORD**



Prenatal Yoga

Consent Form

Phone: 650-723-4600; Fax: 650-724-7514

I request enrollment in the Becoming Parents maternity fitness class called "Prenatal Yoga". I certify that I have given my treating physician the written information about this class, have discussed the risks and benefits of the class with this physician and have obtained the approval of my treating physician to participate. I agree to keep my physician informed of the effects of this class on my body and to obtain approval to continue participation on a monthly basis. I understand that without the written permission of my treating physician, I will not be allowed to enroll or to continue in this class. I also understand that there is no requirement to perform all the class exercises and that I can withdraw from this class at any time.

During this class, I agree to limit my activity to that level which is comfortable for me and to stop all activity if I feel uncomfortable. I will notify the class instructor and my physician if the class activity causes any discomfort. I understand that all forms of exercise involve some risk of injury.

Print Name of Participant

Date:

Signature of Participant

TREATING PHYSICIAN SECTION

I have reviewed the information on the Becoming Parents Program fitness class entitled "Prenatal Yoga". I have discussed with my patient, _____, the benefits and risks of such participation and have assessed her ability to safely perform the exercises involved. I approve of my patient's participation in this class.

List any exercises that this patient should not perform: _____

Date:

Print Name of Treating Physician

Signature of Treating Physician

Telephone