WORKSITE MASSAGETHERAPY PROGRAM
REGISTRATION FORM

Date: ____________

Name:_______________________________________ Sex: ___M ___F

Department:_________________________________ Pony: _______________

E-mail_______________________________________ Phone (Ext.) __________

I. PROGRAM DESCRIPTION

You have registered to participate in the San Mateo County Worksite Massage Therapy Program for County employees.

Massage is a great way to relieve your stress, boost you energy level, promote circulation and makes you feel wonderful. In just 15-20 minutes your neck, shoulders, back, arms and scalp can be thoroughly massaged, leaving you energized, invigorated and ready for the rest of your work day! The certified massage therapist utilizes a special massage chair or table and is trained in the following massage therapy techniques:

-- Shiatsu or Acupressure
-- Chair Massage
-- Reiki
-- Chi Nei Tsang

Based upon your health history and the type of work that you do, the massage therapist will select one or a combination of techniques to design an appropriate session.

Please tell the massage practitioner whenever you feel discomfort during and/or after the massage. Also, please keep the massage practitioner informed about any relevant changes in your health status (see Health Screening Form for specific health indicators).

Participation in the program is on your own time.

II: HEALTH SCREENING FORM For Year:______________

NAME: ____ **PHONE:** ______________

DEPARTMENT: ____________________________________ **PONY:** ______________

As a participant of the Worksite Massagetherapy Program, you are asked to complete a Health Screening form. The Health Screening form is for the exclusive use of the massage therapist, and is used to identify any health conditions or concerns that should be considered during a massage session. You will be asked to update this document at the beginning of each calendar year. In addition, it is your responsibility to keep the massage therapist informed and up to date if you have any health changes prior to any future visits. Upon review of your health information and/or any future updates, the massage therapist may determine that written medical clearance is necessary in order for you to participate in this program.

The massage therapist is solely responsible for maintaining this Health Screening form and all future updates in a confidential and secure manner. The County does not have access to this health information.

INDICATED HEALTH FACTORS

(Please circle YES or NO for each question as it applies to you)

Yes No . . . History of heart problems
Yes No . . . High blood pressure or taking Medication for high blood pressure
Yes No . . . Hypertension
Yes No . . . Osteoporosis
Yes No . . . Shortness of Breath
Yes No . . . Skin Diseases
Yes No . . . Diabetes
Yes No . . . Tumor, growth, cyst, cancer
Yes No . . . History of fainting

Yes No . . . Recent Surgery (within 3 months)
Yes No . . . Pregnant
Yes No . . . Paralysis
Yes No . . . Rupture/Hernia
Yes No . . . Recently torn tendons, ligaments or muscles
Yes No . . . Strained tendons, muscles or ligaments
Yes No . . . Wear a brace or back/ neck support
Yes No . . . Frequent or severe headaches

Yes No . . . Difficulty with physical exercise (dizzy spells, blurred vision, irregular heart beats)
Yes No . . . Muscle, joint or back disorder that could be aggravated by physical movement and activity

I certify that the above information about my current health status is correct and current.
I will keep the Massage Therapist informed if health change(s) occur.
If I have any concerns about the indicated health factors, I agree to contact my doctor prior to receiving a massage.

Signature **Date**

III. LIABILITY RELEASE STATEMENT

(Required for your participation in the Worksite Massage Therapy Program)

I, the undersigned, being over the age of eighteen (18) and of sound mind, do declare as follows:

(1) That I have read fully the Worksite Massage Therapy Program description

(2) That I understand this activity involves a certified massage therapist rubbing and kneading specific muscles and tissues of my body to stimulate circulation and to make my muscles or joints more supple

(3) That I have fully and accurately completed the Health Recommendation/Screening Form and have agreed to inform the massage therapist of any changes in my health status

(4) That I am voluntarily participating in the San Mateo County Employee Health and Fitness Program. I am not participating in this program because of any expectancy or requirement of my employer, expressed or implied. I regard my participation in the Employee Health and Fitness Program as a recreational, social, or athletic activity that does not constitute part of my work-related duties

(5) That in consideration for my acceptance into the program, I hereby for myself, my heirs, executors, administrators and assignees, waive and release all rights and claims from any and all injuries or damages that may be sustained by myself or my property while participating in, or in any way connected with, any and all Employee Health and Fitness Program activities. I further agree to indemnify, save harmless and defend the County, its officers, agents, employees and representative from and against any and all claims and damages, including legal expense and attorney's fees arising out of my participation in the Employee Health and Fitness Program.

I declare under penalty of perjury that the foregoing is true and correct.

______________________________	______________________________
Signature	**Date**