**Yoga Information**

|  |  |  |
| --- | --- | --- |
| **Name** |  | **DOB:** |
| **Do you identify as**  **(Please Tick)** | Aboriginal TSI  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Language Spoken at Home** |  | |
| **Address** |  | |
| **Email &**  **Mobile** |  | |
| **Emergency Contact Details** | | |
| **Name** |  | |
| **Relationship to You** |  | |
| **Email &**  **Mobile** |  | |
| **Medical Information** | | |
| **Tick health concerns that the Yoga instructor should know about?** | Pregnancy  Epilepsy  High blood pressure  Eye diseases, e.g.dislodged retina  Knee and or hip replacement  Spinal operations involving fusing vertebrate or wiring. | |
| **What Medication are you taking?** |  | |
| **How often do you take Medication?** |  | |
| **Carer Information** | | |
| **Name** |  | |
| **Organisation details** |  | |
| **Email &**  **Mobile** |  | |

I consent to relevant information being recorded for statistical and accountability purposes. **I understand that information I provide will be recorded and securely stored at the Women’s Centre.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Woman Date