***The information herein does not replace medical advice**

## Private Massage Consent Form

Massage therapy for a child is not intended to replace other forms of healthcare. Used as a form of adjunctive healthcare, potential benefits for the child include:

| | | |
|---|---|---|
| **Skeletal:**<br>- Aids in supporting good posture and balance<br>- Reduces muscle tension that could lead to potential medical problems<br>- Increases nutrient flow to bones<br><br>**Muscular:**<br>- Relieves muscle tension and spasm<br>- Aids in removal of lactic acid & carbonic acid<br>- Increases the flow of blood and nutrients to muscles<br>- Can increase or decrease muscle tone depending upon amount of pressure<br>- Can reduce or increase joint mobility depending upon amount of pressure | **Digestive:**<br>- May relieve constipation<br>- May relieve gas<br>- Reduces water retention<br>Cleans the blood by toning the kidneys<br><br>**Circulatory:**<br>- Stimulates blood and lymph circulation<br>- Helps strengthen the immune system<br>- Releases toxins held in the body | **Respiratory:**<br>- Improves breathing patterns<br>- Helps reduce respiratory problems<br>- Relieves tension in the chest allowing the lungs to expand more fully<br><br>**Nervous:**<br>- Relaxes and calms<br>- Improves sleep patterns<br>- Raises endorphin levels, promoting healing<br>- Provides a safe and easy release from frustration and hyperactive behavior<br>- The Vagus Nerve is stimulated influencing food absorption hormones (Insulin & Glycogen) |

Child's Name:________________________________________ Birthdate:_______________________

Caregiver's Name : ___________________________________________________________________

Address:______________________________________________________________________________

City:_____________________________________________________State:____________Zip:________

Phone:________________________ Cell/Pgr:_____________________

Email: ______________________________________________________________

Referred By:_________________________________________________________

In case of emergency.

Name: _______________________________________ Phone:_________________

My healthcare provider is:

___________________________________________________ Phone:_________________

Contraindications for Pediatric Massage include:

- Fever/Temperature
- Acute infection, staph infection, illness or disease
- Skin disorder/condition which may be contagious or cause inflammation (fungus, rashes, herpes)
- Open sores, wounds or lesions
- Recent immunization/vaccination (wait 48 – 72 hours)
- Life threatening medical condition
- Unhealed umbilical cord (tummy massage contraindicated)
- Swollen lymph nodes
- Blood clots or a blood condition
- Diarrhea or other sickness
- Inflammation
- High Blood Pressure
- Hernia
- Osteoporosis
- Varicose Veins
- Broken Bones
- Deep Vein Thrombosis
- Pain
- Lability
- Thrombocytopenia

Common Precautions for Pediatric Massage include:

- Apnea
- Bradycardia
- Tachycardia
- Abdominal Distention

- Gastrointestinal or Jejunostomy feeding tubes
- Hydrocephalus
- Inflammations
- Edema
- Dysplasia
- Hemophilia
- Jaundice
- Recent Surgery
- HIV/AIDS
- Tumors
- Cancer
- Seizure Disorders
- Agitation
- Impulsivity

Please indicate any of the high risk factors, complications that I should be aware of:

Is there other relevant information about the pregnancy, child birth, about you or the child, that I should know?

I, ______________________________, understand that my child will be participating in pediatric massage therapy as a form of adjunct health care.

I have noted above all complications, risks, or conditions my child has experienced AND I have obtained my child's healthcare providers release.

I understand that my child will receive pediatric massage therapy as a form of adjunctive health care only and that it is not a substitute for other healthcare provided by a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioner from any claims, liability, demands and causes of action from my and my child's participation in this therapy.

Signature:________________________ Date:________ Print Name:_____________________

Practitioner's Signature:__________________Date:________ Print Name:_____________________

Practitioner's Contact Information:

Audrey Arbuckle, LMT, CPMT, CIMI
Loving Hands On Wheels
317-519-6246
lovinghandsonwheels@gmail.com

## Healthcare Provider Release for Pediatric Massage Therapy

To: Child's Healthcare Provider(s)

Re: Release for Pediatric Massage Therapy

Your Patient's caregiver,_____________________________________, has requested pediatric massage therapy for your patient, ____________________________. This therapy is to be provided by a certified practitioner (certification requires completion of a program of massage therapy or other professional healthcare certification, and an additional comprehensive hands on training program).

It is our policy to provide pediatric massage therapy only if the child's healthcare provider has reviewed this request with the caregiver. In addition, if the child has any high risk considerations, has experienced any healthcare complications or has any contraindicated conditions, we require a written release from the child's healthcare provider stating any specific limitations or precautions that you feel to be appropriate.

Please verify your clearance of this request by your signature below. This verification can be modified or withdrawn at any time should your patient's health status change. Thank you for your time and assistance.

Child's healthcare status is: (please circle one) normal progression special considerations (detail below)

Specific limitations or precautions:

You may contact me directly for clarification or concerns regarding this patient. Yes / No

Healthcare Provider Contact Information:

Name: (please print) _____________________________________Phone:________________

Signature:__________________________ Date:____________

Practitioner Contact Information:

Audrey Arbuckle, LMT,CPMT, CIMI
Loving Hands On Wheels
317-519-6246
lovinghandsonwheels@gmail.com

## Healthcare Environment Medical Consent Form

This consent form below would be used by a member of the healthcare team to obtain parental/caregiver consent after they have received physician consent.

### Documentation of Consent for Pediatric Massage Therapy

I, (print name) ___________________, spoke to the parent/guardian of ___________________ (in person / on the phone) about Pediatric Massage Therapy. I informed them that this is treatment has been cleared by the child's physician.

I discussed risks and benefits of massage. Benefits include relaxation, pain relief and comfort. Risks include allergy to massage oil/lotion(list type) _________________, emotional release related to relaxation, and musculoskeletal soreness.

Opportunity was given for them to ask any questions and these questions were answered.
Questions asked:

___

___

___

The use of an interpreter was required? Yes ☐ No ☐

The parent/guardian stated understanding of this intervention and gave permission for Massage.

**Signatures**

Person obtaining consent: _________________________

Interpreter: ____________________________________________

Date/time:___________________________

Parent/guardian:______________________________________

Witness:_______________________________________________

Date/time:___________________________

**Massage Therapist Treatment Note**

Pt name:_________________________ MR#____________DOB_________
Diagnosis:__________________________________
Date_________ Time Session started:__________ Time ended:__________
Time spent with family/no massage given:_________

Referral form checked for:
() Allergies () Informed consent done
() Assent obtained for patient 7yrs and older who is able to assent

- ❑ Hand washing done prior to treatment

Personal protective equipment applied
() Gloves () Mask () Gown () Other

Permission of patient to touch today obtained
() Verbal () Gesture () Tactile

Duration of patient contact:_____________

Description of massage treatment:
_____________________________________________________________________________________
_____________________________________________________

Position(s)
- ❑ Prone
- ❑ Held
- ❑ Supine
- ❑ Sidelying
- ❑ Sitting

Present during session
- ❑ Parent
- ❑ Nurse
- ❑ Other family members
- ❑ Other:_______________

Patient Response:
_____________________________________________________________________________________
_____________________________________________________________________________________

Concerns/Comments:____________________________________________________________
____________________________________________________________________________

Plan:_______________________________________________________________________

Massage Therapist Name(print):______________________
Signature: