Putney Iyengar® Yoga Centre

®

Julie Hodges CERTIFIED IYENGAR YOGA TEACHER (SENIOR LEVEL)

ENROLMENT FORM

(Please complete both sides)

PERSONAL DETAILS

Name _____

Address _____

_____

_____

Postcode _____

Email: _____

Phone **Mobile:** _____

Home: _____

Work: _____

We are asking you for this information so that we can register you for classes.
We would also like to keep in touch with you and share Centre updates. If you are happy for us to do that please tick this box. ☐

Family/Friend Emergency Contact Details:

Name……

Number……

We are collecting this information on the basis of legitimate interests as defined by the GDPR. Please refer to the Centre Privacy Policy for further information.

Your signature _____ **Date** _____

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This is a confidential document **Putney Iyengar® Yoga Centre**

Declaration Form for Students

Please read the following carefully. Tick the appropriate box and sign below.
It is important to discuss with the teacher where a box has been ticked.
The teacher cannot be held responsible for any problems arising from conditions when information has not been volunteered.

Please declare if you are suffering from the following	**Yes**	**No**	**Medication used**
Hypertension (High blood pressure)			
Heart Disease (angina)			
Have you had a **Heart Attack** (if yes, when?)			
Are you **Diabetic** (diet controlled/inject insulin)			
Have you had treatment for **Cancer**			
Have you suffered with **Detached Retina**			
Have you had **Meniere's Disease**			
Have you been diagnosed with **Multiple Sclerosis**			
Have you received treatment for **ME** (Myalgic Encephalomyelitis)			
Have you been diagnosed **HIV Positive**			
Are you a sufferer of **Asthma**			
Do you suffer with **Allergies** (nuts, latex, hayfever, etc...)			
Do you have **Varicose Veins**			
Do you suffer with **Nose Bleeds**			
Are you **Pregnant**			
Have you had a baby in the last 12 months			
Do you suffer with any **Physical Disabilities**			
Do you suffer with any **Mental Conditions** (depression)			
Have you had any **operations** in the last 3 years (detail below)			
Do you suffer from a: **Neck problem**			
Shoulder problem			
Elbow/Arm problem			
Back problem			
Hip problem			
Pelvic problem			
Knee problem			
Ankle problem			
Further details (including structural damage to your body, operations and treatment received):			
Are you taking any other M**edication or Antibiotics.** **Further details** (if necessary)			

It is important that students bring their medication to class for treatment of Asthma, Diabetes & Allergic Reactions as we do not keep drugs on the premises.
I have completed the above information to the best of my knowledge and have not withheld relevant information.

Name (print)…… ……**Signature**……

Date……