



## **CONFIDENTIAL APPLICATION & MEDICAL RELEASE FORM**

Dear Student,

This form is to apply for course #1205-408, "Spring Kundalini Yoga Detox: Strategies for a Healthy Lifestyle Cleanse," with Shivanter Singh and Simeon Darwick on May 12-17, 2013.

Please read carefully, sign, and return the application by:

Mail:  
Omega Institute for Holistic Studies  
Attn: Registration Dept  
150 Lake Drive  
Rhinebeck, NY 12572

Or scan and email:  
classapplications@eOmega.org

Or scan and email:  
[classapplications@eOmega.org](mailto:classapplications@eOmega.org)

**PLEASE RETURN NO LATER THAN May 2, 2013**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Phone (day) \_\_\_\_\_ (cell) \_\_\_\_\_

Email \_\_\_\_\_

### **MEDICAL HISTORY**

**YES NO**

1. Do you currently have any physical injuries, complaints, or chronic illness at this time?  
If yes, **what & for how long?** \_\_\_\_\_
2. Have you had injuries in the past (i.e. back, knee, shoulder, elbow, etc.)?  
If yes, **what & when?** \_\_\_\_\_
3. Are you currently under the care of a physician or practitioner of any sort?  
If yes, **what for & how long?:** \_\_\_\_\_
4. Are you taking medicines of any type?  
If yes, **what & what for?** \_\_\_\_\_

CLEANSSES ARE POWERFUL TOOLS TO PROMOTE PHYSICAL, EMOTIONAL AND SPIRITUAL HEALING AND CAN IN SOME CASES PRECIPITATE A CHALLENGING REACTION IN ANY OF THESE AREAS. AS THE LIVER DETOXES THERE MAY BE SOME CHANGES IN MEDICATION LEVELS SO BE SURE TO CONSULT YOUR PHYSCIAN BEFORE STARTING THE CLEANSE. DO NOT GO OFF OF YOUR MEDICATIONS FOR THE CLEANSE. IF YOU ARE CONCERNED ABOUT YOUR MEDICATION, CONSULT YOUR PHYSCIAN.

Awakening the Best in the Human Spirit

YES NO

5. Are you on a special diet? If yes, what kind: \_\_\_\_\_

6. Do you have or have you ever had:

a. Diabetes? If yes, are you taking insulin? \_\_\_\_\_  
How much? \_\_\_\_\_ How often? \_\_\_\_\_

b. Seizures?

c. Asthma? (If yes, **please carry your medication/inhalers with you.**)

d. Allergies? To what: \_\_\_\_\_

e. Are you allergic to bee stings?

Type of reaction: \_\_\_\_\_

\*If yes, (**please carry your medication with you on the course**)

YES NO

7. Are you a smoker?

8. Are you pregnant? (**If the answer is yes, please refrain from doing the cleanse.**)

9. Are you currently nursing? (**If so, please refrain from taking any of the herbs on this cleanse. You can just follow the cleanse diet.**)

10. Emergency Contact Name (please print):

\_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Group & ID Number \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date