CONFIDENTIAL APPLICATION & MEDICAL RELEASE FORM

Dear Student,

This form is to apply for course #4005-448, "Cleanse for Women: Tonify, Detoxify & Balance Your Body, Mind, & Spirit," which includes, "The Radiant Power of Women: Mastering the Cycles of Life," with Gurmukh Kaur Khalsa and Snatam Kaur Khalsa **PLUS** a special cleansing regimen led by Shivanter Singh. The dates of the course are August 18-23, 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

PLEASE RETURN NO LATER THAN August 8, 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?** _____

CLEANSES 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.

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