



West Valley Wellness Center Release & Waiver of Liability

- Have you experienced any of these symptoms in the past 7 days:
 1. Non- allergy related cough (no)_____(yes)___
 2. Shortness of breath (no)_____(yes)___
 3. Difficulty breathing (no)_____(yes)___
 4. Chills (no)_____(yes)___
 5. Sore throat (no)_____(yes)___
 6. Loss of taste or smell (no)_____(yes)___

- Have you or anyone you live with has been diagnosed with COVID19 in the past 14 days? (no)_____(yes)___

- I, _____, the Client, or Parent or Guardian of the minor child listed herein, hereby agree to partake in the process of Halotherapy, also known as dry salt therapy, at West Valley Wellness Center.

- I have had the opportunity to investigate this therapy and ask questions of the staff of West Valley Wellness Center. In my research I have determined that this therapy is a safe and reasonable therapy for me, and or the minor listed below, and understand the potential benefits, risks, and consequences of Halotherapy.

- I acknowledge that no one associated with or on behalf of West Valley Wellness Center LLC has made any promise or suggestions that Halotherapy is a cure or substitute treatment for any medical conditions which I may have.

- I acknowledge that West Valley Wellness Center has recommended that all medical conditions and/or concerns be treated by a physician competent in treating that particular condition.

- I acknowledge that Halotherapy has not been evaluated by the Food and Drug Administration and is not intended to diagnose, cure, or prevent any medical condition, including, but not limited to, COVID-19.

- I acknowledge that I have been informed that, although Halotherapy is safe and effective for most individuals, it is not recommended for people with contagious conditions, fever, severe heart disorders, open wounds, cancer, severe hypertension, active tuberculosis, or acute state of respiratory attack.

- I am aware that if I am pregnant or have any serious health concerns, I should consult my physician before engaging in Halotherapy.

- I understand that if I have been tested positive for COVID-19, I should not participate in Halotherapy and should consult my physician instead.

- I understand and acknowledge the contagious nature of COVID-19 and understand that the risk of becoming exposed or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, and I completely release, covenant not to sue, discharge, and hold harmless West Valley Wellness Center and its agents, owners, representatives, and employees from any and all liabilities, claims, suits, actions, losses, damages, costs or expenses of any kind if I do become exposed or infected.
- I understand and agree that my voluntary decision to participate in Halotherapy and/or other practices at West Valley Wellness Center, such as massage therapy, yoga community acupuncture or detox classes, fully and completely release, covenant not to sue, discharge, and hold harmless West Valley Wellness Center, and its agents, owners, representatives, and employees from any, and all liabilities, claims, suits, actions, losses, damages, costs or expenses of any kind that may arise from my participation.

BY SIGNING THIS RELEASE, I HEREBY WARRANT THAT I HAVE NOT KNOWINGLY BEEN EXPOSED TO ANYONE WITH COVID-19 IN THE LAST FOURTEEN (14) DAYS, NOR HAVE I TESTED POSITIVE FOR COVID-19 IN THE LAST FOURTEEN (14) DAYS, NOR HAVE I HAD SYMPTOMS OF COVID-19 IN THE LAST FOURTEEN (14) DAYS.

Participant's Name/ Parent or Guardian's Name (Print)

Participant's Signature/Parent or Guardian's Signature

Date_____