

## Non Disclosure / Waiver Form Dr. Vodder School – North America


### Non-Disclosure

I agree not to copy the handout materials or any portion thereof, unless written permission is obtained from the Dr. Vodder School Instructor or the Dr. Vodder School – North America.


### Waiver

I recognise that I am a participant in this practical course in order to further my knowledge and skill in Dr. Vodder's manual lymph drainage techniques and other related topics, according to the level of the instruction taught. I understand that I will practice on and be practiced on by other participants in the course, in order to learn these techniques. I release the instructor, and any teaching assistants, the sponsoring organization and the Dr. Vodder School – North America and hold them harmless from any and all liability, claims, damages, actions and cause of action whatsoever, for loss, damages or injury to persons or property.

I further agree to disclose in writing below all of my physical and medical conditions, limitations and sensitivities and agree to release and hold the instructor and any teaching assistants, the sponsoring organization and the Dr. Vodder School – North America, harmless from any liability, claims, damages, actions and causes of action in any way relating to or arising from said conditions, limitation or sensitivities. I expressly agree that all instruction and use of all facilities and equipment shall be undertaken at my own risk. I am physically and medically able to undertake any and all instruction provided. All practical classes will require hands-on work both on myself and on others.

I agree to participate in all practical classes (please initial \_\_\_\_\_) 

Please check any of the following conditions for which you currently have or have been treated for within the past six months:

- |   |                                     |                                      |                                 |
|---|-------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Cardiac/pulmonary conditions   | <input type="checkbox"/> Infections | <input type="checkbox"/> Open wounds | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Contagious diseases  | <input type="checkbox"/> Injuries   | <input type="checkbox"/> Thrombosis  | <input type="checkbox"/> Flu    |
| <input type="checkbox"/> Other _____  |                                     |                                      |                                 |
| <input type="checkbox"/> There is nothing to report (please initial _____)  |                                     |                                      |                                 |

Please list any concerns you may have or feel that the instructor should know about:

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Thank you for completing this before the course begins.

Date: \_\_\_\_\_ Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date of Course: \_\_\_\_\_ Course type: \_\_\_\_\_ Location: \_\_\_\_\_

*The information you have provided to us voluntarily will be stored safely and in compliance with Privacy Policy regulations. If you wish to view our Privacy Policy, please contact us or visit our web site at [www.vodderschool.com](http://www.vodderschool.com)*