**INTRODUCTION TO MEDITATION – REGISTRATION FORM**

Name:................................................................................. D.O.B..............................................

Address:.......................................................................................................................................

....................................................................Postcode:.................................................................

Telephone No:.............................................Email:......................................................................

1st Emergency Contact Name:......................................Telephone No:.......................................

2nd Emergency Contact Name:....................................Telephone No:.......................................

Please tick any of the boxes that apply to you

High or low blood pressure: Hearing impairment: Restricted mobility:

Anxiety: Partially sighted: Asthma: Other (please detail)........................

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I confirm the above information is correct.

**Student signature: .............................................................Date:.........................................**

**Student’s responsibility** –Meditation is a safe and effective stress management tool. However, if you have any of the following conditions or are under supervision by the mental health team/health care provider, we will require you to obtain consent from them to attend this meditation course.

**If you tick “yes” to any of the following contra-indications please either provide a letter from your mental health team/health care provider or alternatively sign the declaration below to confirm you have verbal consent from your mental health team/health care provider.**

Depression: Bipolar: Epilepsy: Schizophrenia:

**I declare I have made my mental health team/health care provider aware that I am attending a Beginners Meditation course and I agree that will notify my mental health team/health care provider should my health or symptoms change during the course.**

**Student signature: ..............................................................Date:.........................................**

GDPR regulations.

In order to comply with the GDPR regulations can you please tick the boxes below?

I agree for you to store my data, for the period laid down by your insurance. I understand that this data will be stored securely.

I agree for you to use my data so that you can provide me with information about any future courses that you may be running, or CPD days run by the British School of Meditation.