



## Ready2Heal LLC

Kerstin S Tracy, MS, LMT

CranioSacral Therapy, Sport Science Specialist

NVMT 5312

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### CONSENT FORM FOR CRANIOSACRAL THERAPY FOR A MINOR

I, \_\_\_\_\_, am the parent or legal guardian

(Name of Caretaker)

of \_\_\_\_\_. I am aware of the fact that my

(Name of Minor)

child is receiving Massage or CranioSacral Therapy by Kerstin Tracy, MS LMT,

for the purposes listed here:

(example: stress reduction, muscle spasms, soft tissue injury, pain reduction etc.)

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I understand that CranioSacral Therapy is not intended to be or to replace medical advice or medical treatment, and I should consult with my child's primary care provider, if I have any concern or question about the appropriateness of massage.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date