

Physician/Midwife Approval Form

_____ has a medical approval to participate in a general relaxation massage.

The following restrictions apply (if none, please state so):

Medications:

Physician/Midwife signature

Physician/Midwife name

Street Address

Town

County

Post Code

Phone

Fax

_____/_____/_____
DD MM YYYY

Gestational week as of this date: _____

Please feel free to contact the Pregnancy Massage Therapist directly if you have any questions, or would like any further information: Cherie Weyer, 079 809 72374