



Enrolment Form

Mother's Name _____

Father's Name _____

Email _____

Occupation – Mother _____

Occupation – Father _____

Is this the birth of your 1st 2nd 3rd _____ child?

EDD _____

Location of Birthing _____

Name of Dr/Midwife _____

Would you like information about BirthSkills to give to your Dr or Midwife? YES / NO

Previous Childbirth education classes? Yes – where/when _____
_____ No

General health of mother during pregnancy _____

General fears or concerns? _____

What are the most important things about the birth to you? _____

Any concerns of fears specific to the birth? _____

Please list a few of your favourite things:

Place to be – _____

Activity/Interests – _____

How did you hear about *BirthSkills*?

- Internet
- Ad in newspaper
- Other practitioner
- Magazine article
- Friends/Family
- Brochure
- Other - please state _____



Enrolment Agreement

I hereby state that I am enrolling in the *BirthSkills* class of my own free will and with the understanding that this is a program designed to teach me to use my own natural abilities to bring my mind and my body into a state of relaxation. I further understand that the content of these classes is in no way intended to be represented as medical advice nor as a prescription for medical procedure. I am aware that I should seek the advice of a medical doctor to answer any health-related or pregnancy-related issues surrounding my pregnancy, my labour or my delivery.

I, therefore, agree that I will in no way hold the instructor of the *BirthSkills* classes, Dr Shari Read, or any representatives, responsible for any complications that could arise as a result of my pregnancy, my labour, or the delivery of my child; and I agree that neither I nor any member of my family will make any claim or initiate any suit against any of the above parties now or at anytime in the future.

I hereby declare that, to the best of my knowledge, I am physically and psychologically healthy and able to attend *BirthSkills* classes.

In the best interest of your health, please tell us if you or your partner have or have had any of the following:

- Schizophrenia
- Epilepsy
- Visual and/or auditory hallucinations
- Relaxation induced anxiety
- Clinical Paranoia

Signature

Name of Client

Partner Signature

Name of Partner

