The Academy for the Love of Learning is excited to offer

HOLOTROPIC BREATHWORK™

Academy for the Love of Learning

APPLICATION

Please complete the entire form, including medical information, and return the application to Marianne at breathwork@aloveoflearning.org. We will print out the form and ask you to sign the application when you arrive.

HOLOTROPIC BREATHWORK DATES: September 19 - 22, 2019

FULL NAME:

STREET:

CITY: STATE: POSTAL CODE:

TELEPHONE: (H) (W)

MOBILE PHONE:

EMAIL ADDRESS:

DIETARY RESTRICTIONS:

PLEASE CHECK APPROPRIATE OPTIONS BELOW:

NON-RESIDENTIAL - $625 (Includes: Full Program, 3 breakfasts/3 lunches/3 dinners)

RESIDENTIAL - $780 (Includes: Full Program, 3 nights accommodation-double occupancy, 3 breakfasts/3 lunches/3 dinners) – If single occupancy is available there would be an additional $25/night fee.

I would opt for single occupancy if available

Extra nights – please indicate if you would like to stay at the Academy for any extra nights ($50/night double occupancy - $65/night single occupancy)

Dates of extra nights:

SIGNATURE: DATE:

(To be signed upon arrival at the Academy, we will print it out)

HOW DID YOU HEAR ABOUT THIS RETREAT?

HOLOTROPIC BREATHWORK™

PARTICIPANT INFORMATION & AGREEMENT

Holotropic Breathwork is intended as a personal growth experience, and should not be looked upon as a substitute for psychotherapy. This workshop is not appropriate for pregnant women, or for people with cardiovascular problems, severe hypertension, mental illness, recent surgery, broken bones or fractures, acute infectious diseases, or epilepsy. If you have any doubt about whether you should participate, consult your physician or therapist and the facilitators before attending.

The answers to the following questions are to assist the facilitators and will be kept strictly confidential. Please answer as completely as possible.

MEDICAL BACKGROUND - Do you have a past or current history of:

Yes No Cardiovascular disease, including heart attacks, any cardiovascular surgery and any cardiovascular symptoms such as arrhythmia or angina

Yes No High blood pressure

Yes No Strokes, TIAs, seizures, or other brain or neurological conditions

Yes No Have you had recent surgery

Yes No Have you ever been hospitalized for significant medical issues

Yes No Past or recent physical injuries, including fractures or dislocations

Yes No Recent or current infectious or communicable diseases

Yes No Glaucoma

Yes No Retinal detachment

Yes No Osteoporosis

Yes No Epilepsy

Yes No Asthma (if 'yes', please bring your inhaler to the workshop)

Yes No Are you currently pregnant?

Yes No Have you ever been diagnosed with a psychiatric condition?

Yes No Have you ever been psychiatrically hospitalized?

Yes No Have you ever or are you currently experiencing strong emotions or energies that made it difficult for you to function in daily life?

Yes No Are you currently in psychotherapy or involved in any kind of support group?

Yes No Are you currently taking prescription medication? Please list: _____

Yes No Anything else regarding your physical or emotional status we should know?

If you have answered 'yes' to any of the questions above, please explain your answer at the end of this form.

My health is generally good: Yes No

Age: Gender:
I have participated in a Holotropic Breathwork workshop before: Yes: No:

EMERGENCY CONTACT INFORMATION:

Contact Name:

Phone Number:

AGREEMENT:
I hereby confirm that I have read and understood the above information, and have answered all the questions accurately and completely. I am aware that emotional issues may be evoked during breathwork and that this workshop is not therapy. I understand that it is my responsibility to seek out professional emotional support if needed. In addition, I am aware that the breathwork process may invite physically stressful movement and that it is my responsibility to evaluate whether or not to engage in such movement based on my physical condition. My participation in this workshop is purely voluntary. I elect to participate in spite of the above-mentioned risks.

SIGNATURE DATE

(To be signed upon arrival at the Academy)

PRINT NAME:

Additions to health questions: