Pediatric Client Intake & Parental Consent Form

(For Clients Under 18 – Tennessee Law Requires Parental/Guardian Consent)

Child's Full Name: _____

Date of Birth: _____ **Age:** _____

Parent/Guardian Name(s): _____

Relationship to Child: _____

Phone (Cell): _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Purpose of This Form

This form gives me important health and background information so I can plan a safe, comfortable, and effective massage for your child. All information is confidential and used only to support your child's care.

Note to the Patient

Hi there! I want you to know that your massage session is **for you — not to you.**
That means:

- You are in charge of your own body during your massage.
- Areas covered by a bathing suit will always stay covered.
- You can always tell me if you'd like **more or less pressure**, or if you'd like to skip a certain area — I'll listen.
- Even though your parent or guardian is signing this form, **you also get to decide** if you want to receive massage.
  If at any time you feel unsure or just don't want to continue, you can say **"stop" or "no thank you,"** and that's perfectly okay.
  You're safe with me — this is your space to relax, feel better, and be respected.

Session Goals

Please select any goals that apply for your child's massage:

☐ Relaxation ☐ Pain relief ☐ Improved sleep ☐ Reduced stress or anxiety

☐ Recovery from injury ☐ Improved flexibility or tone ☐ Emotional regulation

☐ Parent-child bonding

☐ Other: _____

Health & Medical History

Primary Care Provider: _____

Clinic: _____ **Phone:** _____

Is your child currently under medical supervision? ☐ Yes ☐ No

If yes, please describe: _____

Current medications, supplements, or treatments: _____

Known allergies or sensitivities:

☐ Lavender ☐ Nut-based products (almond, coconut, etc.) ☐ Essential oils

☐ Lotions or topical ingredients ☐ Sensitive skin ☐ Other:

_____

Any surgeries, injuries, or major illnesses in the past 2 years? _____

Relevant diagnoses or developmental concerns (e.g., autism, sensory processing, ADHD):

Trauma Awareness (confidential):
Please note anything I should be aware of to help your child feel safe and comfortable during their session — for example, if they've experienced medical trauma, foster care transitions, or past touch sensitivity.

(Only share what you feel is helpful. This information stays private and helps me provide trauma-informed, compassionate care.)

Touch & Movement Preferences

How does your child usually respond to touch?

☐ Enjoys gentle touch ☐ Prefers firm pressure ☐ Sensitive to touch ☐ Unsure

Any areas your child prefers to avoid: _____

Specific areas of discomfort, pain, or tightness: _____

Parental/Guardian Consent & Tennessee Regulations

I, the undersigned parent or legal guardian, authorize **Kaci Jones, LMT** to provide professional massage therapy for the child named above.

I understand and agree to the following:

- Tennessee law requires **parental consent for all clients under 18**, and that a **parent or guardian must remain on-site** during sessions for children under 16.
- Massage therapy is meant to support comfort, relaxation, and recovery — it is **not a substitute for medical care**.
- I have disclosed all relevant health information for my child and will update as needed.
- Draping will be used at all times; **bathing suit areas are never uncovered.**
- My child may choose to stop or decline massage at any time, for any reason.
- I consent to communication with my child's healthcare provider only if necessary for safety or coordinated care.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Optional Contact Authorization

☐ I authorize Kaci Jones, LMT to discuss my child's care with their healthcare provider if needed for safety or continuity of care.

Provider Name: _____

Phone: _____
