



Lakewood School of Therapeutic Massage, Inc.  
1102 6th Street. Port Huron, MI 48060 (810) 987-3959  
www.lakewoodschool.com

## Application for Admission

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Last First Middle Home

E-Mail \_\_\_\_\_ Phone \_\_\_\_\_  
Cell / Work

Address \_\_\_\_\_  
Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_

Employment \_\_\_\_\_  
Company Current Title

Education \_\_\_\_\_  
High School Diploma or GED City and State Year of Graduation

College/Advanced Education City and State Year of Graduation

Medical Information (must be able to give and receive massage) : Please circle any of the following that pertain to you.

Contact Lenses, Diabetes, Frequent Headache, Dentures, High Blood Pressure, Heart Problems, Pregnancy, Chronic Back Pain, Blood Clots, Muscle Spasms, Arthritis, Osteoporosis, Digestive Problems, Tumors or Cysts, Acute Injury, Aneurysms, Infectious Diseases.

Please Explain Circled Items: \_\_\_\_\_

Is ongoing medical supervision required? \_\_\_\_\_ Currently taking medication? \_\_\_\_\_ (If yes, please list)

Emergency Contact \_\_\_\_\_  
Name & Relationship Phone #1 Phone #2

How did you learn about Lakewood School? \_\_\_\_\_

Have you received a one-hour professional massage? \_\_\_\_\_  
Date of Massage Name of Therapist

Have you ever been convicted of a felony? \_\_\_\_\_

Fall Program Choice: Tuesday Day Class: \_\_\_\_\_ Monday/Thursday Evening Class \_\_\_\_\_  
*September-June*

Winter Program Choice: Thursday Day Class \_\_\_\_\_  
*February-December*

I hereby state that all of the above information is true to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_