

Disclaimer

Name of the patient (child): _____

Date of Birth: ____ / ____ / _____

Mobile: _____ Email: _____

This is to clarify my/our intention to voluntarily undergo the Neurolink Neurological Integration System (NIS) of health care management performed on my/our child: _____ as described by Didier Fouquet, in accordance with the NIS by Neurolink's Training manual.

I/We have fully understood the potential of corrective reactions from the initial and follow up treatments/sessions, and I/We release Didier Fouquet of any and all liability and/or legal implications that could be interpreted as "not in accordance" with the governing laws of the State of Queensland and the Federal State of Australia.

I/We have a clear understanding this is a unique and different health care management system and fully agree to the full NIS by Neurolink's protocols to be applied to my/our child.

In the case that _____ qualifies for a virus care using the Neurolink NIS System of health management, I/We understand that a specimen of his/her blood is required to perform the correction as described by Didier Fouquet in accordance with the NIS by Neurolink's training manual.

I/we agree and allow my/the NIS by Didier Fouquet to collect a blood sample with a sterile blood sample collecting device and to keep the collected sample on files. **Yes** No

(Initials)

I/We am/are providing a blood sample through my/our own administration With a blood sample collecting device as provided and directed By Didier Fouquet **Yes** **No**

(Initials)

I/we have been advised of possible side effects following a NIS by Neurolink treatments. **Yes** No
I/we understand and accept the potential rectifications and will the practitioner's directions. _____
(initials)

Name of the child as patient: _____ Date: ____ / ____ / _____

Name of legal parent/custodian of the child: _____
(father/mother) (father/mother)

Signature/s _____