WILD CORAL WELLNESS

Medical Clearance for Localized Cryotherapy

Client Name: _____ DOB: _____

Physician / Healthcare Provider: _____ Date: _____

About the Device

Wild Coral Wellness uses the **INSTANTCRYO™ localized cryotherapy system**, a professional handheld device that delivers high-pressure liquid CO_2 to a specific treatment area. According to the manufacturer, INSTANTCRYO™ releases liquid CO_2 at approximately **-108°F (-78°C) and 756 psi (52 bar)** and can rapidly reduce skin surface temperature to approximately **39.2°F (4°C) within about 30 seconds**. Typical localized applications last approximately **30–90 seconds per treatment area**.

Built-in safety features include **intelligent automatic shutoff, proximity sensing, temperature monitoring, treatment-specific nozzles, thermal imaging capability, and manufacturer-developed safety protocols**.

Healthcare providers may research the **INSTANTCRYO™ localized cryotherapy system** at **InstantCryo.com**.

How Localized Cryotherapy Is Used

Unlike whole-body cryotherapy, localized cryotherapy does not expose the entire body to extreme cold. Treatment is directed only to selected areas. Rapid cooling produces temporary local vasoconstriction, followed by natural rewarming and reperfusion.

Wild Coral Wellness uses localized cryotherapy as a supportive wellness and recovery modality. We do not diagnose disease, prescribe medical treatment, or replace care provided by a licensed healthcare professional.

Additional Wellness Activities

Following cryotherapy, Wild Coral Wellness may incorporate **red / near-infrared light therapy** during the rewarming period and may guide clients through **gentle movement, positioning, breathing, or self-directed techniques intended to support normal circulation and lymphatic movement**. These activities do not include manual lymphatic drainage or massage performed by the practitioner.

Reason Medical Clearance Was Requested

Disclosed condition(s), history, or concern:

Area(s) the client would like addressed:

Healthcare Provider Determination

Based upon my knowledge of this patient's medical history and current condition, I have reviewed the localized cryotherapy service described above and:

- I have no medical objection to this patient participating in localized cryotherapy.
- Localized cryotherapy is acceptable with restrictions/modifications: _____
- I recommend postponing localized cryotherapy until: _____
- I do not recommend localized cryotherapy at this time.
- I am unable to make a recommendation regarding localized cryotherapy.

Adjunctive Wellness Activities

Red / Near-Infrared Light Therapy:

- No medical objection - [ ] Avoid - [ ] Restrictions: _____

Gentle Client-Performed Movement / Lymphatic Support:

- No medical objection - [ ] Avoid - [ ] Restrictions: _____

Treatment-Area Restrictions

Areas where localized cold exposure should be avoided, if applicable:

Additional Instructions or Precautions

Healthcare Provider Information

Provider Name: _____ Credentials/Specialty: _____

Practice Name: _____ Phone: _____

Fax / Email (optional): _____

Provider Signature: _____ Date: _____

Important Information

This clearance does not transfer responsibility for the administration of cryotherapy or adjunctive wellness services to the healthcare provider signing this form. Wild Coral Wellness remains responsible for determining whether a session can be performed within its services, training, protocols, and scope of practice.

Medical clearance does not guarantee that services will be performed. Wild Coral Wellness may postpone, modify, or decline a session if information obtained during intake or observation creates a safety concern.

Clients whose healthcare provider does not approve localized cryotherapy, or who are unable to obtain required medical clearance after purchasing a session, will receive a **full refund of the applicable booking price**.

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