CITY OF ROGERS

ADULT WELLNESS CENTER

Membership Form

Rogers Residents $50 Annual Fee
Non-Rogers Residents $60 Annual Fee

Trax ID: # _____ Needs New Card _____ New _____ Renewal _____ SilverSneakers ____ Silver & Fit _____ RenewActive _____ Scholarship _____	**Additional Donations:** Friends of AWC (<$50) ____ Bronze ($100) ____ Silver ($200) ____ Gold ($300) ____ Platinum ($500) ____

First: _____ Middle: _____ Last: _____
(Please Print)

Name I go by: _____ Birth Date: _____

Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____

Gender: ____ Male ____ Female

Ethnicity: ____ Caucasian ____ African American ____ Latin
____ Multi-racial ____ Native American ____ Other

Household Type: ____ Private Home ____ Public Housing
____ Assisted Living ____ Rental

Family Setting: ____ Living alone independently ____ Living with spouse independently
____ Living alone with caregiver ____ Living with spouse with caregiver
____ Living with extended family

Medical Information:
Note: This section is for pertinent information we can provide to first responders in case of an emergency.

Please list any medications:	Please list any allergies:

Please check any known medical conditions:

____ Cognitive Impairment ____ Hearing Impairment ____ Visual Impairment
____ Mobility Impairment ____ My Condition requires an attendant

____ Heart Disease ____ History of Heart Attack ____ Chest Pain ____ High Blood Pressure
____ High Cholesterol ____ Low Blood Pressure ____ Epilepsy ____ History of Stroke
____ Multiple Sclerosis ____ Fibromyalgia ____ Arthritis ____ Back Injury
____ Thyroid Disease ____ Joint Replacement ____ Asthma ____ Pulmonary Disease
____ Severe Obesity ____ Kidney Disease ____ Diabetes ____ Alzheimer's Disease
____ Dementia ____ Parkinson's Disease ____ Osteoporosis ____ Cancer-type: _____
____ Mental Illness-type: _____ Other: _____

PLEASE TURN OVER TO COMPLETE OTHER SIDE

Emergency Contact Information: Please list a primary or local emergency contact.

Name: ______________________________________ Relationship: _______________________

Home Phone: __________________ Work Phone: _______________ Cell Phone: _______________

Please list an additional family member or emergency contact:

Name: ______________________________________ Relationship: _______________________

Home Phone: __________________ Work Phone: _______________ Cell Phone: _______________

Please complete the following questions by circling your answer:

Compared with other people your age, how do you rate your own health?

Much better   Somewhat better   The same   Somewhat worse   Much worse

How many days a week are you currently exercising?

0 1 2 3 4 5 6 7

How many days a week are you currently participating in social or recreational activities?

0 1 2 3 4 5 6 7

Please rate your current energy level (0 = no energy, 10 = full of energy)

0 1 2 3 4 5 6 7 8 9 10

Do you smoke? ____ No ____ Yes (if yes, number of packs/day) ____

Height ________ Weight ________ Blood Pressure __________ Cholesterol ________

I hereby apply for membership with the City of Rogers Adult Wellness Center. I acknowledge that the center is a fitness and activity center and that its programs, events, and equipment use are on a volunteer basis. The membership fee does not include any form of insurance coverage nor does the Adult Wellness Center maintain any sort of liability insurance coverage. I understand and acknowledge that certain inherent risks exist with all types of physical exercise regardless of whether I am supervised by an instructor or participate in such activity by my own direction. I hereby acknowledge that I assume all risks associated with using any services, equipment, or facilities of the Adult Wellness Center. If I am concerned with these risks or with my current health condition, I agree that it is my responsibility to consult my physician before beginning any activity or exercise. I further agree that membership is on a yearly basis and that additional fees may be charged if I choose to participate in certain classes or activities. **No refunds will be given for memberships, classes, or activities**. I hereby agree to follow all of the policies of the center and I agree that my membership is a privilege and may be revoked by the center's staff. I further acknowledge that the Adult Wellness Center, as part of the City of Rogers, enjoys certain rights and immunities under Arkansas Code Annotated Sec. 21-9-301 and that nothing contained in this Membership Form shall act to reduce, modify, negate, or compromise those rights and immunities.

Member Signature ____ Date ____________

Would you be interested in learning about volunteer opportunities at the Wellness Center? ____Yes ____No

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Staff/Volunteer Initials:_____ Date:_______

Method of Payment:	**Total Amount Paid:**	**If member paid more than membership amount, please note below:**	
Cash		**Donation:____**	
Check #__________		**Class Fee:___________________________________**	
Credit Card		**Another Membership:__________________________________**	
Silver Sneakers	**Silver Sneakers #:________-________-________-________**		
Silver & Fit	**Silver & Fit # ____________________________________**		**Paid Fee _________**
Renew Active	**Renew Active #:____**		
Scholarship	**Approved by:______________________________________**		