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 participation in its programs, events, and equipment use is voluntary. 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 I have been encouraged to have health insurance coverage in effect while participating in any member activities. 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. I agree that it is my responsibility to consult my physician before beginning any activity or exercise. I hereby agree to indemnify and hold the City harmless for any injuries or other liability that may occur during my participation at the Adult Wellness Center. 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 hereby grant the City and its assigns the irrevocable and unrestricted right to use and publish photographs and videos of me, for advertising and any other promotional purposes and in any manner or medium; to alter the sale without restriction; and to copyright the same. I understand and acknowledge that photographs and videos taken by the City or its representatives for promotional use are not my own. 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:______________________________________**	