

ADULT WELLNESS CENTER

Membership Form

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

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

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:
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Please check any known medical conditions:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Mobility Impairment | <input type="checkbox"/> My Condition requires an attendant | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> History of Heart Attack | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Severe Obesity | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> 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

Staff/Volunteer Initials: _____ Date: _____ If this was a Pandemic Extension application, please check here _____

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: _____		