Center at the Mall

Date Completed: _____

Tour Guide: _____

Joined Fitness Center: Yes ☐ No ☐

MEMBERSHIP INTAKE FORM

First Name: _____ Middle Initial: _____

Last Name: _____ Nickname: _____

Date of Birth: _____/_____/_____

Are you 60 years of age or older? Yes or No

Gender: _____

Primary Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Home Address: Street 1: _____

Street 2: _____

City: _____ State: _____ Zip Code: _____

County: _____ Tax Municipality/Twp./Boro.: _____

Marital Status: Single Married Divorced Widowed

Are you a veteran? Yes or No

Do you have a disability? Yes or No

Ethnicity: _____

In poverty? Yes or No

Would you like to order a lunch today? Yes or No

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

How did you learn about us? _____

_____

NUTRITIONAL ASSESSMENT

Please circle "YES" or "NO"	YES	NO
1. I have an illness that made me change the kind of food I eat.	2	0
2. I eat fewer than two meals per day.	3	0
3. I eat few fruits, vegetables or milk products.	2	0
4. I have 3 or more drinks of beer, liquor, or wine at most each day.	2	0
5. I have tooth or mouth problems that make it hard to eat.	2	0
6. I don't always have enough money to buy the food I need.	4	0
7. I usually eat alone.	1	0
8. I take 3 or more prescribed or over-the-counter medications a day.	1	0
9. Without effort, I have lost or gained 10 pounds in the last 6 months.	2	0
10. I am not always physically able to shop, cook and/ or feed myself.	2	0

Scoring information: Total Score: _____

[0-2 Low Risk / 3-5 Moderate Risk / 6+ High Risk]

CENTER AT THE MALL FITNESS PROGRAM RELEASE

I understand that there are risks involved with any exercise program. These risks include but are not limited to: cardiovascular complications, stroke, and muscle strain/soreness. I agree to voluntarily participate in the Center at the Mall (CATM) fitness program knowing that these risks exist. I state that I do not have any medical conditions that would restrict my participation in the exercise(s) identified as the "Center at the Mall Fitness Program," or that I have permission from my doctor to engage in unsupervised physical activity. I realize that the use of the fitness center is a privilege and failure to follow proper procedures and policies will result in loss of this privilege. I have been instructed to avoid exercise(s) that cause discomfort, pace myself by taking breaks as needed, and immediately report any abnormal signs and symptoms to the appropriate personnel. I release Lutheran SeniorLife/CATM/Beaver County Office on Aging/Lutheran Service Society and associated personnel from any responsibility or liability that may result from my participation in group classes or from my use of the fitness center. My signature indicates that I understand the physical risks involved in the program, that I agree to participate with knowledge of the risks, and that I hereby release Lutheran SeniorLife/CATM/Beaver County Office on Aging/Lutheran Service Society as stated above from any and all responsibility.

Signature: _____ Date: _____/_____/_____

Center at the Mall

Date Completed: _____

Tour Guide: _____

Enrolled in Silversneakers Online: YES/NO

Participant Name: _____

Phone #: _____ Date of Birth: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: _____

Participant Goals: _____

Please check the following member status upon the completion of paperwork:

- ☐ New CATM Center Member
- ☐ New Fitness Center Member
- ☐ Previous Fitness Center Member with Lapse/Change in Membership

Self Pay Membership Type (CHECK BOX):

- ☐ 1 YR Self Pay 60+ Single Membership
- ☐ 6 MO Self Pay 60+ Single Membership
- ☐ 3 MO Pay 60+ Single Membership Self

- ☐ 1YR Self Pay 60+ Family Membership
- ☐ 6 MO Self Pay 60+ Family Membership
- ☐ 3 MO Self Pay 60+ Family Membership

- ☐ 1 YR Self Pay under 60 Single Membership
- ☐ 6 MO Self Pay under 60 Single Membership
- ☐ 3 MO Self Pay under 60 Single Membership

- ☐ 1 YR Self Pay under 60 Family Membership
- ☐ 6 MO Self Pay under 60 Family Membership
- ☐ 3 MO Self Pay under 60 Family Membership

- ☐ 12 Punch Pass

- ☐ SilverSneakers ID #: _____ Health Plan: _____
- ☐ Renew Active ID #: _____ Health Plan: _____

It is the policy of Lutheran Service Society and the Beaver County Office on Aging to grant prorated refunds for the Fitness Center with proper medical documentation.

Fitness Center Policies & Rules

1. All members must check-in at the Fitness Center desk.
2. SilverSneakers Fitness Program members are required to swipe their card each time they attend classes, use the fitness center gym, or participate in any wellness related classes or events.
3. All exercisers should wear rubber soled shoes. NO sandals/flip flops, shoes with heels, dress shoes, boots, or metal soled shoes are permitted.
4. On days with snowy/rainy weather, please bring a second pair of shoes to change into for exercise.
5. Exercise clothing should be loose fitting and comfortable.
6. After each use, please use the disinfectant to wipe off equipment seats, pads, rails and controls.
7. If equipment is malfunctioning, please notify a staff member immediately.
8. Please do not leave keys or other sharp objects in your back pockets, as this damages equipment seats.
9. We are NOT responsible for lost or stolen items.
10. Remember…if it hurts, don't do it! If any exercise causes pain, you should skip that particular exercise. If the pain persists, inform the fitness staff and see your personal physician.
11. If there is an emergency, immediately notify the staff on duty. DO NOT attempt to help anyone up who has fallen. Encourage him/her to lie still and wait until help arrives.
12. If you experience pain in your chest, shoulder, arm, jaw, head or you feel nauseated, dizzy or light headed while exercising or immediately after exercising, promptly report these symptoms to the fitness staff.

Exercise Readiness Questionnaire

Yes	No	
___	___	1. Has a doctor ever recommended medically supervised exercise?
___	___	2. Have you had chest pain recently or does physical activity cause you to experience chest pain?
___	___	3. Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?
___	___	4. Are you aware, through your own experience or a doctor's advice, of any physical reason that would prohibit you from exercising without medical supervision?

If you answered "yes" to any of the questions above, you are required to provide a completed Medical Clearance Form signed by both you and your doctor.

If you are older than 69 years of age, it is *recommended* that you speak with your doctor before participating in our fitness program. This will not be required for membership.

If you answered "no" to all of these questions there is no further action needed except to sign this form.

Print Name: _____

Signature: _____ **Date:** _____

Your signature signifies that you answered all of the above questions honestly and to the best of your knowledge.

Pandemic Liability Release Waiver - (Must be signed in order to enter Center at the Mall)

In consideration of my participation in the foregoing, the undersigned acknowledge and agree to the following:

☐ I will adhere to all posted safety guidelines, policies, and procedures of **LSS- Center at the Mall** and agree to follow them. I am aware that I may be dismissed from the premises if I do not follow guidelines, policies, and procedures.

☐ With full knowledge of the risks involved, I hereby release, waive, and discharge **LSS-Center at the Mall,** its board, officers, independent contractors, employees, representatives, affiliates, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to the pandemic while participating in any activity while in, on, or around the premises, or while using the facilities that may lead to unintentional exposure or harm due to the pandemic.

☐ I agree to indemnify, defend, and hold harmless **LSS-Center at the Mall** from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to the pandemic.

By signing below I acknowledge that I have read and agree to the LSS- Center at the Mall's New Guidelines and Procedures, and the foregoing Liability Release Waiver and understand its contents; that I am at least eighteen (18) years old and fully competent to give my consent; that I have been sufficiently informed of the risks involved and give my voluntary consent in signing it as my own free act and deed; that I give my voluntary consent in signing this Liability Release Waiver as my own free act and deed with full intention to be bound by the same, and free from any inducement or representation.

Print Name: _____

Sign Name: _____ Date: _____