



Edward M. Armfield, Sr. Civic and Recreation Center, Inc. Silver Sneakers Application

New Membership Information Change Other

First Name _____ MI _____ Last Name _____

Address _____ City _____ County _____ State _____ Zip _____

Mailing Address _____ City _____ County _____ State _____ Zip _____

Date of Birth _____ Join Date _____

E-Mail Address _____ Cell Phone # _____

Home Phone # _____ Business Phone # _____

Emergency Name _____ Emergency Phone # _____

Responsible Party (IF YOUTH MEMBERSHIP) _____

Address (IF DIFFERENT) _____

Spouse _____ DOB _____ Sex _____

Office Use Only	Membership Type			Monthly Fee
Monthly	Silver Sneakers Program			

SILVER SNEAKERS: I understand the Silver Sneakers Fitness Program is an individual membership and not a family membership. In order to qualify I must present my insurance card and a photo i.d. (driver license or state i.d. card) will be copied and kept on file. I will be required to swipe in each time that I use the. I will be required to purchase a key tag as well which will grant entrance into the facility. _____ (initial)

LIABILITY WAIVER: I hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for damages I may have against the Edward M. Armfield Sr. Civic and Recreation Center, Inc. (hereafter known as Center) or their respective agents, representatives, successors, and assigns for any injuries which may be suffered by me in connection with my participation of any activities sponsored by the Center. I understand that I am responsible for monitoring my own condition throughout my activities at the Center. _____ (initial)

I understand that this program may be discontinued at any time by Healthways Silver Sneakers Fitness Program. _____ (initial)

PRIVACY COMMITMENT: As a valued member, we are committed to providing you with exceptional services. We want you to understand what information we collect is strictly confidential.

Applicant Signature _____ Date _____

Staff Signature _____ Date _____

For Office Use Only			
Key Tag Purchase Option	\$5.00 _____	\$10.00 _____	Receipt Number _____

Waiver and Assumption of Risk (HealthWays)

Please consult with your physician before beginning any exercise program.

I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the "Programs"). I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue any class instructor, any Healthways participating location, any sponsoring organization, Healthways, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read and understand this waiver and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location or individual.

In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs.

- Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Diabetes
- Previous hip or spinal fracture (as an adult)
- Lung disease or shortness of breath after mild exertion, at rest, or in bed
- Open cuts on my feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- More than two falls in the past year (no matter what the reason)
- More than one year since I have engaged in regular physical activity

Print Member's Name _____

Member's Signature _____ Date _____

Emergency Contact Name _____ Contact Phone Number _____

