CONFIDENTIAL

OFFICE OF AGING SENIOR MULTIPURPOSE PROGRAM

Dorothy C. Benson Senior Multipurpose Complex

6500 VERNON WOODS DRIVE

SANDY SPRINGS, GEORGIA 30328

404/613-4900

REGISTRATION FORM

All information required unless noted

Please Print

Please Check Facility:

□ *New Participant* □ *Dorothy C. Benson* □ *Harriett G. Darnell*

□ *Renewal* □ *H.J.C. Bowden* □ *Helene S. Mills*

Personal Information

Last Name	First Name	MI

Address	City	State	Zip

Please indicate primary number below for contacting you for One Call Now or Indicate Opt Out

Email – May we include you in the One Call Now? An email to participants informing them of closing, special events etc. If so, please provide your email below.

_____

Home Phone: _____

Cell Phone: _____

Work Phone _____

Birthdate (mm/dd/yyyy)	Gender	Citizenship
_____ / ____ / _____	□ *Male* □ *Female*	□ Immigrant □ Non U. S. Citizen □ Refugee Citizen □ Refugee Non-Citizen □ Resident Alien □ U. S. Citizen

Marital Status	Household
□ *Married* □ *Widowed* □ *Single* □ *Divorced*	□ *Live alone* □ *Live with spouse* □ *Other* □ *Live with family*

Ethnic Group (optional)	Highest Level of Education:
□ *White* □ *Black/African American* □ *Asian* □ *American Indian/Alaska Native* □ *Multi-racial* □ *Hispanic/Latino* □ *Other*	□ *No Formal Education* □ *Less than High School* □ *High School Graduate/GED* □ *Vocational Training* □ *Some college/Associate's degree* □ *Bachelor's degree* □ *Master's degree (post-graduate training)* □ *Doctoral degree*

Present or former occupation	Retired? □ *Yes* □ *No*
Are you or your spouse a veteran? □ *I am a veteran* □ *My spouse is a veteran*	Is your spouse a member of the center? □ *Yes* □ *No*
County of residence: _____ County Commission District: _____	Would you like to be included in the center's phone directory? □ *Yes* □ *No*

Emergency Contact Information		
Doctor's Name		Doctor's Phone Number
Emergency Contact #1		Relationship
Home Phone	Cell Phone	Work Phone
Emergency Contact #2		Relationship
Home Phone	Cell Phone	Work Phone

Mobility

□ *Drives* □ *Public Bus* □ *Family/Neighbor to provide trans. in an emergency*
□ *Owns car* □ *Needs assist in/out of vehicle* □ *Elderly/disabled transit*

Health Conditions:

Do you now, or have you had in the past any of the following:

□ *Chronic illness/Condition* □ *Difficulty with Physical Exercise*
□ *Diabetes or Thyroid condition* □ *Muscle, Joint, Back pain*
□ *High Blood Pressure* □ *Tobacco User*
□ *Obesity* □ *Recent Surgery*
□ *Breathing or Lung Problems* □ *Advisement from physician not to exercise*
□ *Heart Problems* □ *Blood Cholesterol*
□ *Hernia or other condition* □ *Other:* _____

PLEASE EXPLAIN ABOVE ANSWERS:

_____
_____
_____

Applicant Signature	Date

Office Use Only

Date Received: _____
Regular ____ Out of County _____
Amount paid $_____
Check Number _____
Renewal date _____
Received by _____

FULTON COUNTY

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MEDICAL RELEASE FORM

(REQUIRED FOR AQUATICS & FITNESS PROGRAMS)

PHYSICIAN SIGNATURE REQUIRED

**** PLEASE READ AND COMPLETE CAREFULLY****

YOUR PATIENT'S NAME (PRINT) _____ **WISHES TO BEGIN SUPERVISED INDEPENDENT USE OF OUR FITNESS ROOM AND POOL. THIS MAY CONSIST OF GROUP TRAINING PROGRAMS AND WILL INVOLVE THE FOLLOWING FORMS OF EXERCISE:**

1. CARDIOVASCULAR (AEROBIC) EXERCISE USING THE POOL, TREADMILLS AND/OR STATIONARY CYCLES AT A LOW TO MODERATE INTENSITY FOR THREE (3) TO FIVE (5) DAYS PER WEEK.

2. RESISTANCE TRAINING USING CIRCUIT WEIGHT TRAINING EQUIPMENT AND/OR LIGHT DUMB BELLS AT A LOW TO MODERATE INTENSITY FOR TWO (2) TO THREE (3) DAYS PER WEEK.

3. STRETCHING AT LOW TO MODERATE INTENSITY EVERY DAY.

*****IF YOUR PATIENT IS TAKING MEDICATION THAT WILL AFFECT HEART RATE RESPONSE TO EXERCISE, PLEASE INDICATE THE MANNER OF THE EFFECT (I.E. RAISES, LOWERS OR HAS NO EFFECT ON HEART RESPONSE).**

TYPE OF MEDICATION: _____

EFFECT: _____

CONTRAINDICATIONS: _____

PLEASE INDICATE THE PROGRAMS IN WHICH THE PATIENT MAY PARTICIPATE BASED ON THEIR CONDITION. CHECK ALL THAT APPLY:

1. **FLEXIBILITY EXERCISES** _____
2. **AEROBIC/ENDURANCE ACTIVITIES** _____
3. **RESISTANCE TRAINING** _____
4. **SWIMMING/WATER EXERCISES** _____

FOR PHYSICIAN ONLY

_____ HAS MY APPROVAL TO BEGIN EXERCISE WITH THE RECOMMENDATIONS OR RESTRICTIONS STATED ABOVE.

PHYSICIAN'S SIGNATURE FOR APPROVAL: _____ DATE: _____

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WAIVER OF LIABILITY

PLEASE INITIAL

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_____ I understand that all programs/activities involve some risk of accident or injury. I agree to indemnify Fulton County and its affiliates and hold them harmless from any liability, claims, demands and judgments arising at any time when I participate in any program or activity. Therefore, my choice to participate at the "Senior Multipurpose Facilities", including the use of its equipment, is at my own risk. I understand that Fulton County does not provide insurance for participants, nor does it assume responsibility for accidents or injuries. However, Fulton County or its affiliates may require the purchase of additional insurance per participant for certain recreational programs/activities.

_____ I authorize Fulton County personnel associated with the Senior Multipurpose Facilities to act in my behalf to authorize medical treatment to, upon, or for, the benefit of myself for any injury which may occur from my participation. I recognize that such treatment shall be my full responsibility. In the event of a more serious injury that may require emergency medical treatment, I authorize such personnel to see that I am transported for treatment at the nearest medical facility, with the related expense being my full responsibility.

_____ I also here by grant permission to the Fulton County Human Services Department to use for any official purpose any photographs, videotapes, recordings or any other records of program activities depicting myself.

I have carefully read, understand and agree to the policies as stated above.

_____ _____

Signature of Member Date Signature of staffer receiving application Date

Staff Comments: _____

_____

_____