Memorial Healthcare | Wellness Center

COMMUNITY WELLNESS CENTER ENROLLMENT FORM

Please complete the information below to begin our membership enrollment process. If you have any questions, please contact our Wellness Center team at (989) 720-7081 or via email at WellnessCenterHelp@MemorialHealthcare.org. We look forward to seeing you soon!

First Name: ___________________________________ **Last Name:** __________________________________

Birthdate: ____________________________________ **Gender:** ☐ Female ☐ Male ☐ Unspecific

Street Address: ___________________________________**Cell:** _____________________________________

City ____________________ **State:** ____ **Zip:** ________ **Email:** ____________________________________

Emergency Contact Name: _________________________ **Emergency Contact Phone:** _________________

Membership Types (informational only): Age 18+ | Age 16-17 (parent/guardian signature) | Age 13-15 (parent/guardian present)

Membership Type (please check one):
** Please note the one-time initiation fee included with each monthly membership price*

PLEASE CHECK	MEMBERSHIP TYPE AND/OR ADD ON SERVICE	MONTHLY FEE	* ONE-TIME INITIATION FEE
☐	Individual	$ 52	$ 60
☐	Couple	$ 94	$ 120
☐	Dependent Member	$ 32	$ 30
☐	Senior (62+) Individual	$ 46	$ 60
☐	Senior (62+) Couple	$ 82	$ 120
	Guest Pass (Daily)	$ 12	
☐	Locker Room with Laundry Service	$ 15 (6-month commitment, month-to-month thereafter)	

PAYMENT INFORMATION

Payment Method (please check one): ☐ Cash ☐ Check ☐ Credit/Debit Card

If using a credit/debit card, please complete the following. ***We accepted MasterCard and Visa only.***

Card Member (full name): ____

Card Number: ____

Expiration Date: Month _________ Year _________ Security Code: _________

☐ **I understand that my membership is not active until I have completed, signed, and returned the terms and conditions waiver and physical activity assessment. Upon opening of the Wellness Center, please stop by the front desk to receive your membership tag and have your identification photo taken.**

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PHYSICAL ACTIVITY ASSESSMENT

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for most people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor or a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the questions below carefully and answer each one honestly. Check YES or NO.		
QUESTION	**YES**	**NO**
1. Has your doctor ever said that you have a heart condition **OR** high blood pressure?	☐	☐
2. Do you feel pain in your chest at rest, during your daily activities or living, **OR** when you do physical activity?	☐	☐
3. Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing including during vigorous exercise.	☐	☐
4. Have you ever been diagnosed with another chronic medical condition other than heart disease or high blood pressure? **PLEASE LIST CONDITION(S) HERE:** ______________________	☐	☐
5. Do you have a history of CVA (stroke) or TIA (mini stroke)? **PLEASE SPECIFY HERE:** ___________	☐	☐
6. Do you currently have, or have had within the past 12 months, a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active. Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physical active. **PLEASE LIST CONDITION(S) HERE:** _________________________	☐	☐
7. Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.

If you answered YES to any of the questions above, it is recommended that a personalized exercise prescription be provided by one of our certified Exercise Physiologists.

- If you are over the age of 45 and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name: ____ Date:__________________

Memorial Healthcare Wellness Center Staff: ____________________________ Date: _________________

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Second Member ENROLLMENT FORM

Please complete the information below to begin our membership enrollment process. If you have any questions, please contact our Wellness Center team at (989) 720-7081 or via email at WellnessCenterHelp@MemorialHealthcare.org. We look forward to seeing you soon!

First Name: ___________________________________ **Last Name:** __________________________________

Birthdate: ____________________________________ **Gender:** ☐ Female ☐ Male ☐ Unspecific

Street Address: ___________________________________**Cell:** _____________________________________

City _____________________ **State:** ____ **Zip:** ________ **Email:** ____________________________________

Emergency Contact Name: __________________________ **Emergency Contact Phone:** _________________

Membership Types (informational only): Age 18+ | Age 16-17 (parent/guardian signature) | Age 13-15 (parent/guardian present)

Membership Type (please check one):

** Please note the one-time initiation fee included with each monthly membership price*

PLEASE CHECK	MEMBERSHIP TYPE AND/OR ADD ON SERVICE	MONTHLY FEE	* ONE-TIME INITIATION FEE
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QUESTION	YES	NO
1. Has your doctor ever said that you have a heart condition **OR** high blood pressure?	☐	☐
2. Do you feel pain in your chest at rest, during your daily activities or living, **OR** when you do physical activity?	☐	☐
3. Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing including during vigorous exercise.	☐	☐
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5. Do you have a history of CVA (stroke) or TIA (mini stroke)? **PLEASE SPECIFY HERE: ___________**	☐	☐
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Name: ____ Date:____________________

Memorial Healthcare Wellness Center Staff: ________________________________ Date: ___________________