



Prince William Area Agency on Aging  
**SENIOR CENTER MEMBERSHIP FORM**

Date \_\_\_\_\_

Reassessment \_\_\_\_\_

**Name & Vital Information**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
(Street) (City) (zip code)

Phone: \_\_\_\_\_  
(home) (cell)

Email: \_\_\_\_\_ **County** \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Race, Ethnic Origin: \_\_\_\_\_  
(Month) (Day) (Year)

Marital Status: Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single \_\_\_

**Communication of Needs: Circle all that apply**

English Other Language Specify:

Sign Language / Gestures / Device Does Not Communicate

Hearing Impaired? Yes No If yes do you wear a hearing aid? Yes No

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone:(H) \_\_\_\_\_ (C) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone:(H) \_\_\_\_\_ (C) \_\_\_\_\_

**\*THE SENIOR CENTER IS AN INDEPENDENT FACILITY FOR OLDER ADULTS. IF A MEMBER SHOWS A PHYSICAL OR COGNITIVE DECLINE, THE CENTER STAFF WILL COMMUNICATE WITH THE EMERGENCY CONTACT**

I have read and understand the above statement. (Initials)

\_\_\_\_\_



Client Name \_\_\_\_\_

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### EMERGENCY INFORMATION

**Note:** If you require medical attention, 911 will be called. We will do our best to reach your emergency contact. If we are unable to reach your emergency contact, then we will provide the emergency medical personnel with your emergency contact's information.

The Senior Center is not a healthcare provider and will not keep medical information on file. If you have a condition or medication that would benefit emergency medical personnel, please consider wearing an alert bracelet.

**1. Please list current medical conditions staff should know about in the event of an emergency:**

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**2. Please list any medications you are allergic to:**

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<b>Additional Information</b> <i>(circle the appropriate answer)</i>		
No	Yes	Are you eligible for Medicare?
No	Yes	Do you receive Medicaid? If so, membership fee is waived. (Proof required)
No	Yes	If you are single, is your annual income above \$12,060?
No	Yes	If you are married and live with your spouse, is your annual income above \$16,240?
No	Yes	Do you live alone?

No	Yes	Would you like to volunteer at the Senior Center?
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Please list what you are interested in and what days: Front Desk, Kitchen, Deliver Meals on Wheels, Instruct a class or seminar or other \_\_\_\_\_

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**STAFF ONLY**

Type of Payment:

Membership Waiver (Attach)

Special Needs or Additional Information



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*\*It is required that this document be completed to participate in the lunch program*

## **Nutritional Health Screening Survey**

This screening tool was developed by the Nutrition Screening Initiative

CLIENT NAME: \_\_\_\_\_

Date \_\_\_\_\_

Directions: Enter the number of points allowed for each question that you would answer as 'yes' in the Points

2 \_\_\_\_ I have an illness or condition that made me change the kind and/or amount of food I eat.

3 \_\_\_\_ I eat fewer than two meals per day.

2 \_\_\_\_ I eat few fruits or vegetables, or milk products.

2 \_\_\_\_ I have three or more drinks of beer, liquor or wine almost every day.

2 \_\_\_\_ I have tooth or mouth problems that make it hard for me to eat.

4 \_\_\_\_ I don't always have enough money to buy the food I need.

1 \_\_\_\_ I eat alone most of the time.

1 \_\_\_\_ I take three or more different prescribed or over-the-counter drugs a day.

2 \_\_\_\_ Without wanting to, I have lost or gained ten pounds in the last six months.

2 \_\_\_\_ I am not always physically able to shop, cook and/or feed myself.

Your Total \_\_\_\_ If your total nutritional score is:

**0-2** Good! Recheck your nutritional score in six months

**3-5** You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in three months.

**6 or more** You are at high nutritional risk. Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.



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**FITNESS RELEASE**

I, the undersigned, am a member of a Senior Center managed by Prince William County and I am 55 years of age or older. OR I, the undersigned, have paid a daily drop-in fee and am 55 years of age or older. I wish to attend the Senior Center(s) fitness classes and/or use the fitness room and its equipment and I understand and agree as follows:

- (1) I have inspected the room and/or equipment where the exercise will take place and find it safe and suitable for my use. I have taken all steps reasonably necessary to ensure I am physically capable of safely taking the fitness class and/or using the fitness room and equipment.
- (2) I will only use the fitness room and equipment when the Senior Center is open to the public and a class is not being held in the fitness room. If a class is in progress, I will wait until the class is over before using the fitness room and/or its equipment.
- (3) I will sign in and out each time I use the fitness room and equipment and I will read and abide by all Rules and Instructions provided to me and/or posted in the fitness room.
- (4) I understand that taking a fitness class and/or using fitness equipment can be dangerous to my health in that equipment may break, fall or malfunction or I may injure myself through overuse, misuse, or even proper use; or by interaction with others in the class or fitness room. I have taken reasonable steps to follow the instructor and/or learn the proper use of the fitness equipment and I acknowledge that the County has taken reasonable steps to provide qualified instructors and safely install and maintain the fitness equipment. Nevertheless, I take a fitness class and/or use the fitness room and equipment at my own risk and I voluntarily assume all risks of property damage and bodily and personal injury and death, inherent or otherwise, associated with such use.
- (5) I understand that fitness classes, the fitness room and the fitness equipment may be subject to monitoring by camera or undercover surveillance. I waive all causes of action associated with such.
- (6) If I require any reasonable accommodation I have made my needs known to the County and I agree to abide by the County's decision as to whether it can accommodate my needs and, if so, how such accommodation is to be made.
- (7) In consideration of being allowed to use the fitness room and equipment and/or to participate in a fitness class, I hereby waive, release and forever discharge the Board of County Supervisors of Prince William County, Prince William County, their officers, directors, employees, agents and volunteers ("County") from any and all claims, liabilities, and causes of action of every kind arising out of or relating in any way to my use of the fitness room and equipment and/or my participation in a fitness class..
- (8) I agree to indemnify and hold harmless the County from any and all claims and losses of any type, including costs, attorney's fees and appeals, resulting from any of my acts or omissions, or claims or suits filed by me.
- (9) This Release and Assumption of Risk is binding on all my heirs, executors, next of kin and assigns, and all persons who may claim by or through me.

CAUTION: READ THE FOREGOING RELEASE AND ASSUMPTION OF RISK BEFORE SIGNING. THIS DOCUMENT IS VALID UNLESS AND UNTIL REVOKED IN WRITING AND REVOCATION DELIVERED TO PRINCE WILLIAM COUNTY DEPARTMENT OF RISK MANAGEMENT.

MEMBER/DROP-IN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_