Membership Form
Atwood Wellness Center
Kinsley, Ks

_____ _____
NAME(Last) (First & Middle Initial)

_____ _____
ADDRESS (Mailing) (City, State, Zip Code)

_____ _____ M_____F_____
PHONE (Home) (Birth Date) (Sex)

_____ _____
EMPLOYER (Name & Address) (Phone)

_____ _____
PERSONAL PHYSICIAN (Address & Phone)

_____ _____ _____
EMERGENCY CONTACT (Relationship & Address) (Phone)

TYPE OF MEMBERSHIP (Check One):

Individual____Senior____Family____(If family, how many 14 & older)____Corporate____
Name of person(s) (other than self) on Family Membership or Corporate Membership. Please indicate if 14 to 17 years old.

_____
_____
_____

If I have a FAMILY MEMBERSHIP, by signing below, I hereby give my parental/guardian consent and assume responsibility for use of the facility by my family member(s) 14 - 17 years of age.

Liability/Waiver of Claims

It is expressly agreed that all use of Edwards County Wellness Center facilities shall be undertaken at member of guest=s risk, and Edwards County Wellness Center shall not be liable for any injuries or any damages to any member or guest, or be subject to any claim, demand, injury, or damage whatever, including, without limitation, those damages resulting from acts of active or passive negligence on the part of Edwards County Wellness Center, its employees (if any), officers, directors, or agents. The member or guest, for himself or herself, and on behalf of his/her executors, administrators and assigns, expressly releases and discharges Edwards County Wellness Center, its successors, and assigns as well as its employees, officers, directors, and agents, for all such claims, demands, injuries, damages, actions, or cause of action. Edwards County Hospital reserves the right to cancel the membership of any member found abusing or misusing the equipment in the Wellness Center.

I hereby affirm that I have read and fully understand the above, that I have received a copy of the Rules of Edwards County Wellness Center and agree to abide by them.

Date:_____ **EDWARDS COUNTY WELLNESS CENTER**

_____ **By:_____**
SIGNATURE **REPRESENTATIVE**

_____ **PAID$_____(CASH OR CHECK)**
SIGNATURE(PARENT/GUARDIAN)

ATWOOD WELLNESS CENTER

Please answer the following general health questions. If you mark any of the following we recommend you consult your physician prior to beginning an exercise program.

Have you had or do you now have:

Dizziness or fainting.....Yes/No
Convulsions or seizures.....Yes/No
Paralysis (including polo).....Yes/No
Difficulty in breathing.....Yes/No
Swelling of ankles.....Yes/No
Heart Trouble (chest pain at rest or with exertion).....Yes/No
Arthritis or rheumatism.....Yes/No
High Blood Pressure.....Yes/No
Skin Rash.....Yes/No
Frequent Backache/Back Pain.....Yes/No
Hay Fever/Asthma.....Yes/No
Hernia or rupture.....Yes/No
Cancer.....Yes/No
Orthopedic problems including joint or foot trouble.....Yes/No

Do you smoke.....Yes/No

Have you ever injured yourself while exercising.....Yes/No

If yes, list nature of injury and date it occurred.

_____
_____
_____

Please list any family history of heart disease, diabetes, stroke, or high blood pressure.

_____
_____
_____

Please list any other significant medical information and anything pertinent to your exercise program.

_____
_____