Logan County Rehabilitation and Wellness Center

906 W 2nd Street, Oakley, KS 67748

785-672-8167

Member Registration

Name _____ **Birth Date** _____

Home Address _____ **Home Phone** _____

City _____ **State** _____ **Zip** _____ **Work Phone** _____

Emergency Contact (Name) _____

Emergency Contact (Phone) _____

E-mail address (optional)_____

E-mail addresses may be used to contact you with payment due reminders or important member notices.

Type of Membership **Single** _____ **Couple** _____ **Family** _____ **Student** _____

Couple and family memberships, please list all names and DOB to be included in the membership:

Name _____ **Relationship** _____ **DOB** _____

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I hereby register as a member of the Logan County Rehabilitation and Wellness Center. I acknowledge having received a copy of the Code of Conduct and I agree to abide by the same. Furthermore, I agree to pay all prevailing monthly dues so long as I or any of my other immediate family members retains membership. I understand my membership is nontransferable and dues are subject to change. I am aware and understand that I am responsible for monitoring my own condition through the exercise program and should any unusual symptoms occur, I will cease my participation and immediately inform the Wellness Center Staff or seek medical attention. All information obtained as a result of my utilization of this facility for participation in any programs shall be treated as privileged and confidential. This information may be used for billing, statistical or scientific purposes with my right of privacy mentioned. In consideration of the Logan County Rehabilitation and Wellness Center accepting this application, I release and discharge Logan County Rehabilitation and Wellness Center, it's employees, any and all persons connected with the facility from all rights, claims, demands and actions of any and every nature whatsoever for any and all loss, damage, injuries sustained by me or my property.

Signature _____ **Date** _____

Accepted by _____ **Date** _____

Anyone purchasing membership for the first time is urged to make an appointment with our staff for an orientation and equipment instruction to help start your fitness journey.

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FITNESS AND MEDICAL QUESTIONNAIRE

Name:_____ Date of Birth:_____

Yes	No	
☐	☐	Has your doctor ever told you that you have heart or lung problems?
☐	☐	Have you frequently felt any chest discomfort or pain?
☐	☐	Do you generally experience dizziness and/or faintness?
☐	☐	Has your doctor ever told you that you have high blood pressure?
☐	☐	Do you take medication to lower your blood pressure?
☐	☐	Are you aware of any bone, back or joint problems that could be aggravated with exercise? (e.g. arthritis)
☐	☐	Have you ever had an episode of exercise-induced asthma, severe wheezing, coughing, or severe shortness of breath brought on by exercise?
☐	☐	Have you ever been told by your doctor that you have diabetes?
☐	☐	Are you older than age 65 and not involved in regular exercise?
☐	☐	Is there any reason why you should not engage in exercise? (e.g., surgery during the past six months) Please explain:_____

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that if I answered "Yes" to any of the questions listed above, medical clearance from my physician is required. In such event, I hereby authorize the Logan County Rehabilitation and Wellness Center at Logan County Hospital to contact my provider in order to obtain medical clearance, which will allow me to participate in exercise and/or a fitness program.

Applicant Signature_____ Date_____

If any questions were answered as YES, we will request medical clearance from your primary care provider.

MEDICAL CLEARANCE FORM

This is only required for individuals answering "Yes: to any of the above questions. I hereby certify that, to the best of my knowledge, the above stated person has no contraindication to participation in an exercise and fitness program.

Please Print Providers Name_____Provider's Phone #_____

Provider's Signature_____ Date_____

Print Name_____ Phone_____

Address_____ City/State_____ Zip _____

Limitations (if any)_____

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MEMBER WAIVER

PLEASE READ CAREFULLY! THIS IS A LEGAL DOCUMENT, WHICH AFFECTS YOUR LEGAL RIGHTS!

WAIVER AND RELEASE OF LIABILITY

ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

In consideration of being permitted to use the Wellness Center facility, including all equipment, state and agree as follows on behalf of myself and my personal representatives, next of kin, heirs, executors, administrators, agents, and assigns:

1. I understand that any physical exercise or activity involves the risk of bodily injury, including permanent disability, paralysis, and death. I understand that such injury may be caused by my own actions or inactions, or the actions or inactions of others.
2. I agree to engage in any physical exercise or activity and to use the facility at my own risk. This includes, but is not limited to, the following: (a) my use of the parking area, sidewalk, equipment, and any other amenity in the facility; (b) my participation in any activity in the facility; and (c) use of any information, instruction, advice, example, direction, or suggestion I receive through any means while at the Fit for Life facility. I agree that I am voluntarily engaging in these activities and using the facilities, equipment, and amenities. I assume all risk of injury, illness, damage, or loss of any kind resulting from such activities and usage, including, but not limited to, any loss or theft of personal property.
3. I agree to release and discharge Logan County Hospital, (and its affiliates, employees, agents, representatives, successors, and assigns) to the fullest extent permitted by law, from any and all claims or causes of action (known or unknown) arising out of any negligence on the part of LCH. If, despite this agreement, I, or anyone on my behalf, makes a claim against LCH, I will indemnify, save, and hold harmless LCH from any litigation expense, attorney fees, loss, liability, damage, or cost LCH may incur as a result of such claim.

I have read this agreement and fully understand its terms. I have had an opportunity to ask any questions I may have concerning this agreement, and all such questions have been answered to my satisfaction. I understand that this agreement cannot be modified orally. I understand that I have given up substantial rights by signing this agreement. I have signed this agreement freely and without any inducement or assurance of any nature. I intend this agreement to be a complete and unconditional release of all liability to the fullest extent allowed by law. I agree that if any portion of this agreement is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

SIGNATURE_____ DATE_____

PRINTED NAME_____

WITNESS SIGNATURE_____