

Brookline Senior Center

FITNESS CENTER APPLICATION

Thanks for your interest in the Fitness Center!

Here is some basic information:

We currently have 5 Nautilus strength-training and 5 cardiopulmonary conditioning machines. We also have large exercise balls, hand and ankle weights, elastic bands, and other equipment. A well-designed fitness routine includes Flexibility, Strengthening, Stretching, Balance and Cardio work.

The Fitness Center is open **Monday through Friday from 8:30 am to 4:30 pm.**

The Fitness Center membership fee is \$35 per month.

Payment is due the first week of each month with no pro-rated payments due to missed sessions.

Payment may be made with a personal check payable to the **Brookline Senior Center** or through the website, www.brooklineseniorcenter.org, under donations. Please make sure to note that the payment is for the Fitness Center. We also offer opportunities for those who cannot afford these payments.

There is also a one-time \$35.00 fee for the initial pre-program assessment. During this assessment, you and the Fitness Coordinator will review your health status and your health/exercise goals, gather some baseline measurements, develop your initial exercise plan, and schedule work-out times. Same payment options as above.

We stay current with local, state and federal protocols concerning COVID-19 and its variants. This may change our policies and procedures in the future.

Getting Started

To become a member of the Fitness Center complete the 5 included forms and return all of them to Courtney Johnston, the Fitness Coordinator, or put in her mailbox at the 2nd Floor Admin desk.

- Member Information Form
- Health Status & Exercise Screening Questionnaire
- Admission Agreement Form
- Liability and Waiver Form
- Medical Information Release

I will send your physician your signed medical release form and a Physician's Clearance Form. When I get the Physician's Clearance Form back, I will contact you and we will arrange a time for the pre-program assessment.

I can be contacted by visiting the Brookline Senior Center, Fitness Room on 2nd - Floor, #205, by phone **617-730-2106**, or email: **cjohnston@brooklinema.gov**

Courtney Johnston, Fitness Coordinator

Brookline Senior Center

FITNESS CENTER

Member Information

Participant Name _____ Date of Birth _____

Address _____ Home phone _____

City, State Zip _____ cell _____

Email _____ work _____

Emergency Contact

Name _____ Relationship _____

Address _____ Home phone _____

City, State Zip _____ cell _____

Email _____ work _____

Physician _____ Phone _____

Address _____ Fax _____

_____ Email _____

City, State Zip _____

For Office Use Only

Health Status Questionnaire

Participant Name: _____ Date: _____

Birth Date: _____ Age: _____ Gender: _____

Marital Status: Single___ Married___ Domestic Partnership___ Widow___ Divorced___

Living Situation: ___Alone ___With_____

What is your current Height ___' ___" Weight _____

Present/Past History

Have you had OR do you presently have any of the following conditions? (Check if yes.)

___ Alzheimer's/Dementia

___ Arthritis

___ Back pain

Blood Pressure: ___ High ___ Low

___ Cancer If yes, type _____

___ Congestive Heart Failure

COPD:

___ Asthma, ___ Bronchitis, ___ Emphysema

___ Depression

___ Diabetes

___ Edema (swelling of ankles)

___ Heart Attack

___ Hernia

___ High Cholesterol

___ Hip Fracture

___ Injury to back or knees

___ Memory Loss

___ Osteoporosis

___ Parkinson's

___ Seizure

Joint Replacement(Specify) _____

Other Fracture (Specify) _____

Contraindication (Specify) _____

Other (Specify) _____

Check all types of drugs you are taking either for treatment or preventive purposes

_____ None

_____ Diuretic (water pill)

_____ High Blood Pressure

_____ Antidepressant

_____ Diabetes

_____ Anxiety

_____ Shots for Diabetes

_____ Sleeping Medication

_____ Laxatives

_____ Heart Medication

_____ Nitroglycerin

Other _____

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Hearing:

Do you have a hearing impairment? Yes ___ No ___

Do you wear a hearing aid? Yes ___ No ___

Vision: Do you have a visual impairment? Yes ___ No ___

Please specify _____

Are you able to read newsprint? With eyeglasses ___ OR Without eyeglasses ___

Check primary device you use: None ___

Walker ___ Cane ___ Wheelchair ___ If so, when? _____

Check each activity you need assistance with: None ___

Getting up from the chair ___

Dressing ___

Getting on and off the toilet ___

Climbing stairs ___

Bathing ___

Grooming/Hair Care ___

Walking across a small room ___

Eating ___

Exercise Screening Questionnaire

Please read the questions listed below. Check yes or no opposite the question as it appears to you.

Yes No

___ ___ 1. Do you have chest discomfort/aches that happen when resting or with exertion?

___ ___ 2. Has a physician diagnosed these pains? Diagnosis _____

___ ___ 3. In the past month, have you had chest discomfort when you were doing physical activity?

___ ___ 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

___ ___ 5. Are you short of breath at rest, at night in bed, or after very mild exertion?

___ ___ 6. Do you get pain in your buttocks or the back of your legs (thighs or calves) when you walk?

___ ___ 7. Do you often have fast, irregular, or very slow heart rates while you are resting?

So that we can plan the best fitness program for you, tell us why you are joining the program?

Check ALL that apply.

Get stronger ___

Increase my independence ___

Improve my flexibility ___

Increase my endurance ___

Opportunity to meet others ___

Improve my balance ___

Other _____

Improve my walking ability ___

Brookline Senior Center (BSC)
Fitness Center
93 Winchester St. Brookline, MA 02446
Phone 617-730-2769 Fax 617-730-2761

Admission Agreement

I understand that the BSC Fitness Center membership is a monthly membership. If I am absent from the program as a result of an illness or injury that required the care of a physician, or a hospitalization, the BSC Fitness Center will require a medical clearance to return. In this case, the BSC Fitness Center may adjust the fee for the affected month. I recognize that I will not be permitted to return to the Program until the clearance is received from my physician.

I understand that if I am absent from the Fitness Center for more than 2 months, BSC Fitness Center reserves the right to require a new assessment with the Fitness Coordinator/Certified Personal Trainer.

If I require supervision, I understand that if I unable to come to my session, I will notify the Fitness Coordinator before my scheduled session. I also understand that the staff will attempt to find an alternate session time for me.

I understand that on occasion, a fitness staff member may need to reschedule a session. I understand that every effort will be made to notify me in advance and accommodate my schedule.

I understand that non-restricting clothing and comfortable non-skid shoes are recommended.

I will not attempt to adjust or use the equipment until the Fitness Coordinator has determined that I am competent to do so.

I will not use any piece of equipment until all settings have been adjusted to my fit.

I will report any and all symptoms that occur while I am using the equipment ***immediately*** to the staff member. If I experience discomfort after the session, I will report this to the staff member at the beginning of my next session. This includes but is not limited to chest discomfort, jaw, neck or shoulder discomfort, muscle or joint discomfort, and/or shortness of breath.

I authorize the BSC Fitness Center staff to contact my Physician in the event that they feel I need further medical evaluation.

If I decide to stop attending the Fitness Center at the Brookline Senior Center, I will notify the staff before the end of the month.

I accept responsibility for any and all fees, as applicable.

I understand that if I do not follow policies, procedures and instructions, or present a danger to myself or others as a result of participation, I am subject to removal from the program.

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in the Brookline Senior Center Fitness Center.

Through my participation in the Fitness Center, I may derive many benefits that would improve my ability to perform activities of daily living and therefore enhance my quality of life. Some of these benefits may include, but are not limited to improved strength, balance, flexibility, energy and endurance. I understand that the exercise results will vary with each individual. I also realize that participation in any physical activity may result in a potential health risk, and that I assume willfully those risks. I understand that I may stop or delay my participation in any activity or procedure if I so desire, and that I may also be requested to stop and rest by the Fitness Program staff who observes any symptoms of distress or abnormal response.

I have had the opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I understand the risks of my participation in this activity, and knowing and appreciating these risks I voluntarily choose to participate, assuming all of these risks.

Notes of questions and answers

This is, as stated, a true and accurate record of what was asked and answered.

Participant Signature

Date

Responsible Party (if applicable)

Date

Fitness Coordinator/Designee

Date

Brookline Senior Center
FITNESS CENTER
Medical Information Release

Participant Name: _____ Date: _____

At the Brookline Senior Center, Fitness Center, your safety and well-being are our primary concern. For this reason, we require that you obtain authorization from your physician before you start your exercise program. We recognize that you are eager to get started and therefore, by completing this form, you will help us speed up this process.

To expedite this process we will gladly fax the necessary forms directly to the physician of your choice. If the doctor is aware of your medical history, she/he may be able to complete the consent form and fax it right back to us. In some cases, a doctor may choose to have you schedule an appointment for a consultation or evaluation.

I hereby give my physician permission to release any pertinent medical information from my medical records to the staff at the Brookline Senior Center, Fitness Center. All information will be kept confidential.

Participant Information

Signature of Participant or Personal Representative

Date

Printed Name of Participant or Personal Representative

Personal Representative's Relationship to Participant

Physician Information

Physician Name

Office Telephone Number

Office Address

Brookline Senior Center
Fitness Center

Liability Waiver and Release Form

I, _____, wish to participate in the Brookline Senior Center, Fitness Center. In consideration of such participation, I hereby agree to indemnify and save harmless, the Town of Brookline, its elected and appointed officials, employees and agents, from and against all loss, damage, claims, demands, suits, judgments, liability or expenses by reason of any property damage or personal injury that I may suffer and which may be claimed to have arisen as a result of or in connection with my participation in the Fitness Center. I understand that before beginning any exercise program, it is best to consult a physician and it is my responsibility to do so.

Participant Signature _____

Date _____