BROOKLINE COUNCIL ON AGING

SENIOR CENTER FITNESS CENTER APPLICATION

THANK YOU 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 8:30am to 4:30pm**
- Membership is **$35 per month**
- Payment is due the first week of each month with no pro-rated payments due to missed sessions

Prior to membership, **there is a one-time $35 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.

Payment may be made with a personal check payable to the **Brookline Senior Center** or through the website: www.brooklineseniorcenter.org, by clicking on the red *DONATE* button. Please make sure to choose "Fitness Membership" under Category and note that the payment is for the Fitness Center. We also offer opportunities for those who cannot afford these payments.

Getting Started

To become a member of the Fitness Center, complete the 5 included forms and return all of them to the Fitness Coordinator's mailbox by the 2nd Floor Information Desk.

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

The Fitness Coordinator will send your physician your signed medical release form and a Physician's Clearance Form. When the Fitness Coordinator receives the Physician's Clearance Form back, they will contact you and arrange a time for the pre-program assessment.

The Fitness Coordinator can be contacted by visiting the Brookline Senior Center Fitness Center, 93 Winchester Street- 2nd Floor, or by phone at **617-730-2777.**

THANK YOU!

BROOKLINE SENIOR CENTER FITNESS CENTER

Member Information

Participant Name: _____ Date of Birth: _____

Street Address: _____ Primary Phone: _____

City, State, Zip: _____

Cell Phone (if different from primary): _____

Work Phone (if applicable): _____

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ Cell: _____

Email: _____

Work Phone (if applicable): _____

Physician Contact

Physician Name: _____

Name of Hospital or Practice: _____

Phone: _____ Fax: _____

Address: _____

Email: _____

---------- **For Office Use Only** ----------

BROOKLINE SENIOR CENTER FITNESS CENTER

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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Health Status Questionnaire (continued)

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	___

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Admission Agreement

I understand that the Brookline Senior Center (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.

BROOKLINE SENIOR CENTER - Admission Agreement (continued)

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 related to 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**

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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:_____

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 Brookline Senior Center 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/Responsible Party Signature

_____

Date