



SECONDFIT MEMBERSHIP APPLICATION

Membership Types:

- | | | | |
|---|----------------|--|----------------|
| <input type="checkbox"/> Individual | \$25 per month | <input type="checkbox"/> Senior Individual (70+) | \$20 per month |
| <input type="checkbox"/> Married Couple | \$35 per month | <input type="checkbox"/> Senior Married (70+) | \$30 per month |
| <input type="checkbox"/> Family | \$55 per month | <input type="checkbox"/> Parent +2 Children | \$35 per month |

Initiation Fee: \$45

Name _____

Address _____

City, State _____ Zip _____

Home phone _____ Mobile _____

DOB ____/____/____ Age _____

Email Address _____

Emergency Contact _____ Phone _____

Are you a member of SBC? _____ If not, where? _____

SBC Bible Study Member? _____ If yes, which class? _____

Are you a parent of an SBS student? _____

For staff use only:
 Date ____/____/____
 PAR-Q Complete? ____
 Health History Complete? ____
 Waiver Signed? ____
 Does applicant need
 physician approval? Yes/No
 Staff Initials _____

Spouse Membership Information

Spouse's Name _____ DOB ____/____/____

Emergency Contact _____ Phone _____

Family Memberships

Please PRINT the name(s) of all family members

	Age	DOB
1. _____	_____	____/____/____
2. _____	_____	____/____/____
3. _____	_____	____/____/____
4. _____	_____	____/____/____

FAMILY MEMBERSHIP INFORMATION

All members 15 years and older will be issued a key fob upon completion of the PAR-Q form.

Children 13-15 are allowed to use equipment ONLY if supervised by their parent.

The Family Membership includes 2 hours of free childcare per day while you exercise.

Memberships must be canceled in writing. Cancellation will take effect 30 days after written notice. Canceled members will pay a \$45 reinstatement fee to return to membership.

Fitness Center Payment Options

Fitness Center monthly fees can be paid through Credit/Debit or EFT.

Fee Options:

Membership Types:

Individual	\$25 per month	Senior Individual (70+)	\$20 per month
Married Couple	\$35 per month	Senior Married (70+)	\$30 per month
Family	\$55 per month		

Initiation Fee: \$45

Locker Rental:

(If you are interested in an assigned locker, please complete the Locker Rental form)

Half Locker: \$5 per month

Full Locker: \$10 per month

Credit Card Authorization:

Name on Credit/Debit Card: _____

Cards accepted: Mastercard Visa Discover American Express

Credit/Debit Card Number: _____

Expiration Date: ____/____/____

Signature _____ Date ____/____/____

-OR-

Direct Debit (EFT)

I hereby authorize the Family Life Center of Second Baptist Church to initiate debit entries to my checking account indicated below and my financial institution named below to debit the same to such account.

Financial Institution: _____

Routing Number: _____

Account Number: _____

This agreement is to remain in full force and effect until the Second Baptist Fitness Center has received written notification from me of termination or modification of the agreement in such time and in such manner as to afford Second Baptist Fitness Center and its bank a reasonable opportunity to act on it. I wish to pay Family Life Center program and service fees by way of electronic transfer of funds. This agreement will be implemented when my next payment is due.

Signature _____ Date ____/____/____



SECOND FIT Physical Activity Readiness Questionnaire (PAR-Q)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these question. Please read the questions carefully and answer each one honestly:**Check YES or NO**

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month, have you had chest pain when you were not doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you know of <u>any other reason</u> why you should not do physical activity?

**If
you
answered**

YES to one or more questions

Talk to your doctor by phone or in person **BEFORE** you start becoming much more physically active or **BEFORE** you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want—as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- Start becoming much more physically active—begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness appraisal—this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

Delay becoming much more active:

- If you are not feeling well because of a temporary illness such as a cold or a fever—wait until you feel better; or
- If you are or may be pregnant—talk to your doctor before you start becoming more active.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name _____

Signature _____ Date _____

Signature of parent _____ Witness _____

Or Guardian (for participants under the age of majority)



HEALTH HISTORY

SECONDFIT QUESTIONNAIRE

Each Member over 15 years of age must complete the Health History Questionnaire.

Name _____

Home Address _____

Home _____ Mobile _____

Height _____ Weight _____ Gender _____ DOB ____/____/____ Age _____

Physician _____

Physician Address _____

Physician Telephone _____

Regular physical activity is safe for people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with (Second's Family Life Center), please read the following questions carefully and answer each one honestly. All information will be kept confidential. **Please check YES or NO:**

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever experienced a stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have emphysema? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you feel pain in your chest when you engage in physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have chronic bronchitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past month, have you had chest pain when you were not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness? |

11. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
12. Has a physician ever told you or are you aware that you have high blood pressure?
13. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?
14. Has a physician ever told you or are you aware that you have a high cholesterol level?
15. Do you currently smoke?
16. Are you a male over 44 years of age?
17. Are you a female over 54 years of age?
18. Are you currently exercising LESS than 1 hour per week? If you answered no, please list your activities.

19. Are you currently taking any medications? Please list the medications and its purpose _____

Please indicate any special medical condition, medication or devices that limit physical activity not mentioned above:

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Printed Name _____ Date ____/____/____

Signature _____

SECOND FIT RELEASE, WAIVER AND AUTHORIZATION FOR MEDICAL TREATMENT (ADULT)

IN CONSIDERATION FOR ALLOWING ME TO BE A MEMBER OF THE FAMILY LIFE CENTER ("FLC") AT SECOND BAPTIST CHURCH AND PARTICIPATE IN ACTIVITIES AFFILIATED WITH THE FLC AND SECOND BAPTIST CHURCH, I DO HEREBY, RELEASE SECOND BAPTIST CHURCH, ITS STAFF, LEADERSHIP, EMPLOYEES, AGENTS, REPRESENTATIVES, CHAPERONES, VOLUNTEERS, AND ASSIGNS; SECOND BAPTIST SCHOOL, ITS STAFF, LEADERSHIP, EMPLOYEES, AGENTS, REPRESENTATIVES, CHAPERONES, VOLUNTEERS, AND ASSIGNS, AND SECOND BAPTIST SCHOOL FOUNDATION, ITS STAFF, LEADERSHIP, EMPLOYEES, AGENTS, REPRESENTATIVES, CHAPERONES, VOLUNTEERS, AND ASSIGNS (ALL OF THE FOREGOING RELEASED PARTIES ARE COLLECTIVELY REFERRED TO AS "SECOND BAPTIST CHURCH") FROM ANY AND ALL CLAIMS AND LIABILITIES OF WHATSOEVER NATURE, BOTH INDIVIDUALLY AND COLLECTIVELY, THAT MAY ARISE FROM MY PARTICIPATION IN ANY ACTIVITIES AFFILIATED WITH SECOND BAPTIST CHURCH, WHETHER OR NOT SUCH ACTIVITIES OCCUR ON THE PROPERTY OF SECOND BAPTIST CHURCH AND WHETHER OR NOT SUCH CLAIMS OR LIABILITIES ARISE OUT OF THE NEGLIGENCE OR OTHER CONDUCT OF SECOND BAPTIST CHURCH I RECOGNIZE, UNDERSTAND, AND ACKNOWLEDGE THAT THE ACTIVITIES IN WHICH I WILL OR MAY PARTICIPATE INVOLVE RISKS, INCLUDING BODILY INJURY OR EVEN DEATH, BUT I AM NEVERTHELESS VOLUNTARILY AND KNOWINGLY PARTICIPATING IN THOSE ACTIVITIES AND AM FULLY RELEASING SECOND BAPTIST CHURCH FROM ANY AND ALL CLAIMS FOR SUCH INJURY OR DEATH.

I further agree that Second Baptist Church representatives have the authority to authorize or provide such emergency medical, dental, surgical care or treatment for me and are authorized to make all medical, dental or surgical care decisions as may be necessary in their judgment on my behalf. I understand that I will be financially responsible for any costs incurred in my emergency treatment and/or transportation and agree to reimburse Second Baptist Church within thirty (30) days for those expenses. This authorization shall be effective until it is expressly revoked.

I understand I may be treated by a volunteer health care provider and that the volunteer health care provider is not administering care for or in expectation of compensation. I also understand and agree that the volunteer health care provider is immune from civil liability for an act or omission resulting in death, damage, or injury as long as the volunteer health care provider acts in good faith and is in the scope of his or her duties in providing the health care services.

Second Baptist Church has my permission to use, without any compensation, any photographs, videos, recordings or other media of me for the purposes of brochures, videos, advertising, website, or other promotional items, and waive any right of ownership to such media or other claim that I may have to receive any royalty or other compensation for such use. I further understand that these photos/videos will be used for Second Baptist Church promotional purposes only.

I acknowledge that I have read and understand all aspects of this agreement and, by my signature, indicate agreement with the terms set forth in this document. I agree that copies, scans or faxes of my signature are accepted as binding. I acknowledge that this Release, Waiver and Authorization for Medical Treatment is effective until I submit a new or updated Release, Waiver and Authorization for Medical Treatment and I agree to provide updated information as necessary.

I have had the opportunity to speak with legal counsel regarding this document and, in consideration for my participation, understand that I am giving up any and all claims against Second Baptist Church.

Participant Signature _____ Date _____

Printed Name _____