



**Douglas County Board of Commissioners
Lithia Springs Senior Center
55+ Senior Recreational Facility
7301 Groovers Lake Rd., Lithia Springs, GA 30122**



Membership Information

Please Print

Date: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number:

Preferred contact method: Home Phone ___ Cell Phone ___ Email ___

Would you like to receive notifications via TEXT? Standard messaging rates may apply:

Yes ___ No ___

Email Address: _____

Are you a Douglas County resident? Yes ___ No ___

If not, what county do you live in? _____

Are you a member of The Woodie Fite Senior Center? Yes ___ No ___

If so, what is your card number? _____

Emergency Contacts

Please provide three (3) emergency contacts to be contacted considering an emergency.

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

What amenities are you interested in?

Please circle all that apply.

Pickle Ball

Gym

Dance

Therapeutic Pool

Café Lounge

Computer Center

Library

Game Room

Additional Comments or

Suggestions? _____

Are you interested in any specific clubs or committees?

Did you serve in the military? Yes/No What Branch? _____

Membership Fees for Douglas County Residents:

Douglas County Resident: **\$50.00** Annual Fee/**\$25.00** Annual Fee for Spouse

Please note Therapeutic Pool Access is an additional charge.

Douglas County Resident Therapeutic Pool Access: **\$25.00** Spouse: **\$12.50**

Non-Douglas County Resident:

Non-Douglas County Resident: **\$75.00** Annual Fee/**\$50.00** Annual Fee for Spouse

Please Note Therapeutic Pool Access is an additional Charge.

Non-Douglas County Resident Therapeutic Pool Access:

Non-Douglas County Resident: **\$25.00** Annual Fee/**\$ 25.00** Annual Fee

Please note the Membership Fee does NOT include the cost of certain classes or activities.

I would like to have access to the “**Activity Center Only**” _____

I would like to have “**Full Access**” to the Activity Center and the Therapeutic Pool _____

Payment Arrangements Available Upon Request.

Method of Payment:

Please Circle Option

Cash

Credit Card/Debit Card

Check

Program Participation Release

I, _____, fully understand that my participation or attendance in any program, class offered, or use of facility amenities; including the Therapeutic Pool is strictly voluntary. To my knowledge I do not have any conditions that would prevent me from utilizing the programs, classes offered, or facility amenities. I also acknowledge that if I have any reservations or concerns about my medical condition, it is my responsibility to consult with the appropriate medical personnel prior to participating in any program, class offered, or utilization of facility amenities; including the Therapeutic Pool.

In addition, on behalf of myself, my next of kin, or my heirs, I release Douglas County, its officials, employees, volunteers, agents, and the Lithia Springs Senior Center from all liability/responsibility; for any injury, illness, or death resulting from the use/participation in any program, classes offered, or use of facility amenities.

I understand and agree that any photos or videos of myself may be used on social media or in publications for the Lithia Springs Senior Center.

I am satisfied and understand the potential risk of this program, activities, and use of facility amenities at the Lithia Springs Senior Center.

Signature of Acceptance: _____ **Date:** _____

I have received the new “*New Member Information Handbook*” and I agree to adhere to the Lithia Springs Senior Center policies for the privilege of membership at the Lithia Springs Senior Center.

Signature of Acceptance: _____ **Date:** _____

The following information is optional. This information is needed for current grant requirements and future grant applications. This information is kept strictly confidential.

Are you a Veteran: Yes ___ No ___? If so, what branch? _____

Race/Ethnicity: ___ Black/African American

___ White/Caucasian

___ Native American

___ Hispanic

___ Asian

___ Pacific Islander

___ Other

___ I choose not to answer.

Check below the number of persons in your household, and on the same line, check whether the household income is above or below the dollar figure shown on that line.

- 1 person household income ___ above ___ below \$40,250
- 2 person household income ___ above ___ below \$46,000
- 3 person household income ___ above ___ below \$51,750
- 4 person household income ___ above ___ below \$57,450
- 5 person household income ___ above ___ below \$62,050
- 6 person household income ___ above ___ below \$66,650
- 7 person household income ___ above ___ below \$71,250
- 8 person or more household income ___ above ___ below \$75,850

Renew Active by United Healthcare Members Only:

Renew Active ID# _____

Participation in the Renew Active® program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership. Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, discounts, classes, events, and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. AARP Staying Sharp is the registered trademark of AARP. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. For Medicare Advantage and Prescription Drug Plans: A Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare. Benefits, features and/or devices vary by plan area. Limitations and exclusions apply. Medicare fitness programs for body and mind is not related to Medicare Supplement plans.

Silver Sneakers Members Only:

Silver Sneakers ID# _____

Waiver and Assumption of Risk Please consult with your physician before beginning any exercise program. I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the “Programs”).

I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Tivity Health Services, LLC participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Tivity Health™ Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Tivity Health participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Tivity Health Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing).

I also hereby release, waive, discharge and covenant not to sue any class instructor, any Tivity Health participating location, any sponsoring organization, Tivity Health, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Tivity Health Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

In addition, I agree that Tivity Health may engage in – and I hereby expressly consent to – (i) the recording (in video and/or still photo format) of my participation in Tivity Health classes, workshops or other programs, and (ii) the publication or other use by Tivity Health of any such recordings in social media, broadcast media, print media, general advertising and similar purposes. I have read and understand this waiver and express assumption of risk.

I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit.

This waiver and release shall survive the term of any agreement with a Tivity Health participating location or individual. In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs. • Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure • Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots • Frequent fast, irregular heartbeats OR very slow heartbeats • Diabetes • Previous hip or spinal fracture (as an adult) • Lung disease or shortness of breath after mild exertion, at rest, or in bed • Open cuts on my feet that do not seem to heal • An unexplained weight loss of ten (10) pounds or more in the past six (6) months • More than two falls in the past year (no matter what the reason) • More than one year since I have engaged in regular physical activity

Print Member's Name _____ Member's Signature _____
Date _____ Emergency Contact Name _____
Contact Phone Number _____

Douglas County Senior Services Waiver and Release of Liability Form

Release of Liability, Waiver of Claims, Assumption of Risk, and Indemnity Agreement

PLEASE READ CAREFULLY. BY SIGNING THIS DOCUMENT, YOU CHOOSE TO WAIVE CERTAIN RIGHTS, INCLUDING THE RIGHT TO SUE.

To: Participants and Patrons

I wish to use Douglas County Facilities for activities during the COVID-19 Crisis. By engaging in Douglas County Facilities, I recognize and fully understand certain things, including:

- My use of the facilities for activities involves certain risks, including but not limited to:
 1. Exposure to COVID-19
 - a. Those who may have come in contact with anyone exposed with the virus.
 - b. Surfaces that are touched by those who may have been exposed to COVID-19.
 2. The risk of injury resulting from facility usage during activities.
 3. The risk of other injuries resulting from participating in any action on the premises.
- I recognize and fully understand that the above list is not a complete or exhaustive list of all possible risks; the list only provides examples of types of risks that I am assuming. In exchange for Douglas Senior Services letting me use the facilities and premises during this COVID-19 Crisis, I hereby agree to the conditions below.

I fully intend and choose to give up the legal rights, as stated below:

1. TO WAIVE ANY AND ALL CLAIMS, to include but not limited to bodily injury, or COVID-19 and diseases that I may have in the future against any elected official, Board of Commissioners, Owner, its directors, officers, employees, agents, or representatives (hereinafter referred to as the "Releasees") relating to my participation and use in Douglas County Senior Services facilities.
2. TO RELEASE THE RELEASEES from any and all liability for any loss, damage, injury, expense, or other cost that I may suffer or that my next of kin may suffer in connection with my use of the Releasees facilities and premises to any cause whatsoever, INCLUDING NEGLIGENCE ON THE PART OF THE RELEASEES;

3. TO HOLD HARMLESS AND INDEMNIFY THE RELEASEES from any and all liability to property, or personal injury to, any third party, resulting from the use of the facilities and premises.

4. That I am over the age of 18 and that I am responsible and will adhere to all the rules of the property.

5. That this Waiver, Release, and Agreement is fully effective and binding upon me, and my heirs, next of kin, executors, administrators, and assigns, or anyone else authorized to act on my behalf or on behalf of my estate. I have read and understood this document. I am aware that by signing this document, I am waiving certain legal rights that I may have against the Releasees, and I fully agree to do so.

Signed: _____

Print: _____

Date: _____

Date of Birth: _____

PERSONAL INFORMATION CONSENT FORM

Douglas County Senior Services is excited to announce that we soon will be moving to a new and more efficient class and activity registration system. Specifically, we will be using the MySeniorCenter platform, which will provide an online-based system to register and sign-in for classes and activities.

To make the transition seamless, we need to share our existing database with MySeniorCenter while it is developing the platform for us. You are receiving this notice because the database we will be sharing contains basic demographic information about you and other Members who have used our services in the past. This information includes your name, address, telephone number, and email address. It does not contain your Social Security number, date of birth, driver's license number, financial information, passwords, or other sensitive personal information. In addition, MySeniorCenter will only use the information to create the system for Douglas County so that everyone's information will already be there when we make the switch.

But because we respect people's choices about their information, we wanted to notify you about this in advance and confirm your permission to share or not to share your information. If you have questions about this, please contact us at 770-920-7575 and we will be happy to discuss it with you. Otherwise, please sign and date the form below and return it to us.

By allowing us to share with MySeniorCenter, your information will be included in the new system when it goes live, and you will be able to use it beginning on day one. If you do not give permission, or we do not receive your signed form by the date above, then your information will not be shared with MySeniorCenter and will not be included in the new system. As a result, you will need to later enter your information and register yourself in the new system once it goes live to register for and sign-in to future classes and activities.

OPTION 1:

By signing below, I give permission for Douglas County Senior Services to share my name, address, telephone number, and email address with MySeniorCenter for the purposes described above.

Printed name: _____ Date: _____

Signature: _____

OPTION 2:

By signing below, I do not give Douglas County Senior Services permission to share my information with MySeniorCenter for the purposes described above.

Printed name: _____ Date: _____

Signature: _____