Always Active[SM] Registration Form

Date of Enrollment: _____ **Person Completing Form:** _____ **Agency:** _____

GOLD CARD ID # _____

[ ] **Registered at Senior Center**? What Center: _____

Last Name: _____ **First Name**: _____ **Middle Name**: _____

Date of Birth: _____ **Age**: _____

Address: _____ **Cross Street**: _____

City: _____ **State**: _____ **Zip Code**: _____ **County**: _____

Home Phone: _____ **Cell Phone**: _____

Email: _____

Emergency Contact Information:

Name: _____**Relationship to Participant**_____

Address: _____

City: _____ **State**: _____ **Zip Co**de: _____

Home Phone: _____ **Cell Phone**: _____

Physician's Contact Information: _____

Gender: [ ] Male [ ] Female [ ] Trans Male [ ] Trans Female [ ] Genderqueer/ Gender Non- Binary
[ ] Not listed, please specify _____ [ ] Decline to state

Sex at Birth: [ ] Male [ ]Female [ ] Decline to state

Sexual Orientation or Identity: [ ] Heterosexual [ ] Bisexual [ ] Gay/ Lesbian/ Same Gender Loving
[ ] Questioning/Unsure [ ] Not listed, please specify _____ [ ] Declined to state

Ethnicity: _____ **Preferred Language**: _____

English Fluency: [ ] Fluent [ ] Limited [ ] Needs Translation [ ] Unknown

Special Needs Assessment: [ ] Low-income (self-reported) [ ] Frail (req. assistance, cane, walker, many falls)

How did you hear about Always Active[SM]?_____

What type of insurance do you have? _____

Always Active Liability Release Form-English

RELEASE FORM FOR THE ALWAYS ACTIVE PROGRAM

1. **VOLUNTARY PARTICIPATION:** I, _____ (name of participant) acknowledge that I have voluntarily applied to participate in the Always Active Program for seniors at one of the premises of Always Active [SM] located in the city and county of San Francisco, California.

2. **ASSUMPTION OF RISK:** I am aware that participation in the Always Active Program may be a hazardous activity due to my age and/or physical condition. I am voluntarily participating in these activities with knowledge of the danger involved. I hereby agree to accept any and all risks of injury or death, and verify this statement by placing my initials here. _____

3. **RELEASE:** As consideration for being permitted by Always Active [SM] to participate in this Program, I hereby agree that I, my assignees, heirs, distributees, guardians and legal representatives will not make a claim against Always Active [SM], 30th Street Senior Center, a program of On Lok Day Services, San Francisco Senior Center, Inc., University of San Francisco, and any or all other local Senior Centers offering the Always Active [SM] Program for my injury or death resulting from the negligence or other acts, howsoever caused by any employee, agent or contractor of Always Active [SM], 30th Street Senior Center, a program of On Lok Day Services, San Francisco Senior Center, Inc., University of San Francisco, and the local Senior Center offering the Always Active [SM] Program in connection with my participation in this Program. I hereby release Always Active [SM], 30th Street Senior Center, a program of On Lok Day Services, San Francisco Senior Center, Inc., University of San Francisco, and the local Senior Center offering the Always Active [SM] Program from all actions, claims or demands that I, my assignees, heirs, distributees, guardians and legal representatives now have or may hereafter have for injury or death to me resulting from my participation in this Always Active [SM]

4. **KNOWING AND VOLUNTARY EXECUTION:** I have carefully read this release and fully understand its contents. I am aware that this is a release of liability and a contract between myself, 30th Street Senior Center, a program of OnLok Day Services, San Francisco Senior Center, Inc., and the University of San Francisco, and I am signing it of my own free will.

5. I have been advised that it is a good idea to see my doctor before beginning this program.

EXECUTED AT SAN FRANCISCO, CALFORNIA ON

Date: _____

RELEASOR

_____

(YOUR SIGNATURE)

Medical History Form

Please read the questions carefully and mark an **X** for each. Please answer the questions honestly. **If you answer "yes" to any of the first six questions below, we will require a Medical Release Form within 30 days of your first class.**

	YES	NO
1. Has your doctor told you that you need medical supervision during exercise because of your health status? If yes, explain.		
2. Do you feel pain, pressure, heaviness, or tightness in your chest when you do physical activity?		
3. In the past month, have you had chest pain when you were NOT doing physical activity?		
4. Have you been told by your doctor that your diabetes is not under control? If you don't have diabetes leave it blank.		
5. Have you been told by your doctor that your chronic Kidney disease is not under control? If you don't have kidney disease leave it blank.		
6. Have you experienced heart failure or other heart conditions? If yes, when?		
7. Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
8. Is your doctor currently prescribing drugs for your blood pressure or a heart condition?		
9. Have you experienced hip or knee surgery ?		
10. Have you experienced back problems?		
11. Do you know of any other reason you should not do physical activity? If yes, explain:		

The Always Active staff and instructors will emphasize basic exercise safety and precautions, however, the participant will need to know, his/her physical limitations and must take responsibility to exercise accordingly. If at any point the instructor deems the class not safe for the participant due to frailty or inability to follow instruction, the instructor will refer them to another program and/or require a Physican's Release.

I certify that all the information in this form is correct to the best of my knowledge and will notify the Always Active instructor of any changes in my health that may be affected by physical activity or exercise.

Name:_____ Signature:_____ Date:_____

Always Active Program
30th Street Senior Center's
PHOTO/VIDEO RELEASE FORM

I hereby grant the Always Active Program permission to use my likeness in a photograph or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration.

I understand and agree that these materials will become the property of the Always Active Program and will not be returned. I hereby irrevocably authorize the Always Active Program to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing the its programs or for any other lawful purpose.

In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge the Always Active Program from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____ (Signature)
(Date)

_____
(Printed Name)

always active
Seniors moving to better health

Patient's Name: _____

Medical Release Form

Dear Doctor:

Your patient has expressed interest in participating in the Always Active[SM], a program designed to enhance the overall well-being for adults over the age of 60, and promote socialization by providing an array of services that include; exercise classes to increase overall strength, balance, aerobic conditioning, and flexibility. Please assist us in determining whether your patient is appropriate for participating in any of our programs below:

YES *NO* *(Please mark one box in each row with an X)* *Classes also offered in Spanish & Chinese

☐ ☐ ***Fall Prevention Program:** A 12-week program where participants engage in exercises for lower extremity strength, standing static & dynamic balance, gait enhancement, and sensory/vestibular stimulation.

☐ ☐ **Strength & Flexibility:** Classes include moderate intensity exercises using weights, resistance tubing, stretching, and balance exercises. Participants must be able to perform standing exercises for 60 minutes. Chairs are available for participants to use if needed. (No individual assistance- must be able to exercise independently).

☐ ☐ **Aerobics (No Direct Supervision):** Use of treadmills, recumbent and/or stationary bicycles. These exercises are likely to induce an increase in heart rate.

_____ _____

Patient's Name Date

_____ (_____)_____

Medical Professional's Name (Please Print) Telephone

_____ _____

Address License Number

Please return this form to your patient or send via fax, or mail to the program below.

Health Promotion – Fax: 415 550-2255; Tel: 415-550-2265

30th Street Senior Center; 225 30th Street, San Francisco, CA 94131

lvillaneuva@onlok.org; www.alwaysactive.org

For Always Active[SM] Staff Use Only

NEW _____RENEWAL_____ AA[SM] Member #_____

Registered by: _____ PR Form Expiration: _____

Site Name: _____