LAKESHORE

Veteran Membership Application

Member #_____

Date (MM/DD/YYYY)_____

First Name ◯Mr. ◯Mrs. ◯Ms. _____ Middle Initial ____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Age _____ ◯Male ◯Female ◯Non-binary

Address _____ City _____State _____ Zip _____

Phone _____ ◯Cell ◯Home Email _____

County ◯Jefferson ◯Shelby ◯Blount ◯St. Clair ◯Tuscaloosa ◯Walker ◯Other _____

Race/Ethnicity ◯Asian/Pacific Islander ◯Black/African American ◯Hispanic/Latino
◯White/Caucasian ◯Native American ◯Other _____

Emergency Contact _____ Relation _____ Phone _____

Branch Served _____ # of Years Served _____

Do you have a service-connected disability? ◯Yes ◯No

To qualify for our veteran membership, you must provide a copy of your DD-214 or your Military ID.

How did you hear about Lakeshore's Veteran Membership? ◯Internet ◯Social Media ◯News/TV
◯Physician ◯Friend/Fellow Veteran ◯Lakeshore Staff Member ◯Other _____

Primary Disability or Health Condition (if applicable) _____

Primary Care Physician _____ Clinic Name _____

Phone _____ Fax _____

Membership Package

Premier - Access to Lakeshore Online Fitness, Lakeshore facility, classes and programs, including the aquatics center & aquatics classes

Additional Individuals on Membership

The Veteran Membership is applicable to the veteran and any individuals who live in the same household. Proof of residence for additional individuals is required.

Name _____ DOB _____ Disability (if applicable) _____

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Name _____ DOB _____ Disability (if applicable) _____

Name: _____

Membership Terms

A. **Duration of Membership:** Lakeshore membership is continuous for a minimum of one year and not transferable or refundable after 30 days (see 'Member's Right To Cancel' section below). After your first year, membership will automatically renew month to month.

B. **Member's Right to Cancel:** To cancel, written notice of your intent must be delivered or postmarked on or before the last day of the month, and you must bring your account balance to zero. Members agree to pay charges for goods, services and monthly dues, whether the facilities are used or not, until termination of membership. Please mail, provide written notice handed in person, or email cancellation notice to: membership@lakeshore.org. Lakeshore Foundation Attention: Membership 4000 Ridgeway Drive Birmingham, AL 35209

C. **Cancellation of Membership by Lakeshore Foundation:** Lakeshore Foundation reserves the right to immediately terminate the membership of any member engaging in conduct in violation of this contract or the rules and regulations of Lakeshore Foundation.

D. **Medical Conditions:** If you are unable to participate in programs for an extended period of time (one month or longer) due to a medical condition, your membership may be placed in an inactive status after receipt of written documentation from your physician. There will be no re-enrollment fee to reactivate your membership.

E. **Continuous Membership:** Membership automatically renews each month after the first year. If you cancel your membership or allow it to expire, a re-enrollment fee may be charged and a new membership application must be submitted.

_____ (initial)

Release and Indemnity

I hereby agree that all use of Lakeshore Foundation's facilities, premises, programs and services including transportation shall be undertaken at my sole risk and Lakeshore Foundation shall not be liable for any injuries, accidents or deaths occurring to applicant, arising either directly or indirectly out of utilizing Lakeshore Foundation's facilities, services and programs, whether caused by the negligence or other wrongful conduct of Lakeshore and any of its agents or employees. The applicant for himself(herself) and on behalf of his(her) executors, administrators, heirs, and assigns, does hereby expressly release, discharge, waive, relinquish, and covenants not to sue Lakeshore Foundation, its officers and agents for all such claims, demands, injuries, damages or cause of action, with respect to use of Lakeshore Foundation facilities, premises, programs and services which the applicant may suffer or incur as a result of participation in such program, whether or not caused by the negligence or wrongful acts of such persons or any agents, servants or employees of any of them. I do further agree to indemnify and hold harmless each of them, of and from any and all claims, demands or actions of any kind or nature whatsoever arising out of any injury or damages incurred by the Applicant. In signing this release, I acknowledge and represent that I am over 19 years of age, I am of sound mind, I have read this release, understand it, and sign it voluntarily, and that this paper contains the entire agreement between myself and Lakeshore Foundation. The Applicant declares that he(she) is physically able to participate in physical activity. Further, Applicant declares that Lakeshore Foundation has advised him(her) to obtain a medical clearance if he(she) is unsure of his/her physical health.

_____ (initial)

Audio/Visual Consent

I hereby consent and authorize the taking of photographs, movies, films, videotapes, tape recordings, or reproductions (collectively, “Reproductions”) of the persons who are hereby applying for membership and consent to use, copyright, license, publication or broadcast of the same for advertising, educational, promotional, or publicity purposes on the part of Lakeshore Foundation and by its affiliated and associated organizations, including its directors, officers, agents, servants and employees. I hereby grant and assign to Lakeshore Foundation the right, title, and irrevocable authority and interest to such Reproductions. I waive any and all claims for compensation and waive any and all claims related to or arising out of the publication and dissemination of the same of any lawful purposes. I further authorize the communication of information concerning the undersigned in connection with the utilization of such Reproductions by Lakeshore Foundation and its affiliated or associated organizations, and their respective directors, trustees, officers, agents, servants and employees without claim for compensation and waive all claims related to or arising out of the publication and dissemination of the same.

_____ (initial)

Member Email Communication

We regularly provide information about our hours of operation, programs and services, education-al content and other information aligned with and supporting our mission via email. By sharing your email address you agree to receive these emails. You may opt out of these emails at any time by using the “unsubscribe button” or contacting Member Services. Lakeshore never sells or shares your information with external organizations or companies.

_____ (initial)

Program Evaluation/Research

I hereby consent and authorize the use of information I provide for use in program evaluation and research where needed. I understand that my personal information will be kept confidential and will only be accessed by authorized staff.

_____ (initial)

Membership Agreement

Below are the signatures of all persons applying for memberships who are at least 19 years of age, and signatures of guardians for all persons applying for membership who are less than 19 years of age. I HAVE READ AND AGREE WITH THE TERMS OF THIS CONTRACT, and any questions were answered to my full satisfaction. I will follow Lakeshore Foundation’s rules and regulations, amended from time to time, and Lakeshore Foundation’s failure timely to enforce, in whole or in part, its rights, privileges or powers under this contract shall not operate as a waiver thereof. I have received a copy of this contract.

_____ Date _____

Member or Parent / Guardian Signature (if member is under 19 years of age) *By using an electronic signature, you agree it is the legal equivalent of your manual signature on this agreement.*

_____ Date _____

Family Member Signatures (all members 19 years of age or over)

Health History

Date (MM/DD/YYYY) _____

Name (please print) _____ DOB (MM/DD/YYYY) _____

Check any of the following that apply to your health (currently or in the past): The information you provide will help us develop an individualized plan to help you meet your goals.

- ☐ I do not have any of the listed conditions
- ☐ Heart Condition - if yes specify _____
- ☐ High Blood Pressure or on Blood Pressure Medicine
- ☐ Cardiac Surgery - if yes, what kind and when _____
- ☐ Pain in your chest while DOING physical activity
- ☐ Pain in your chest while NOT DOING physical activity
- ☐ Diabetes Hypoglycemia (low blood sugar

Respiratory Disease (check all that apply)

- ☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke – when and how affected
- ☐ Arthritis (Type: ◯ Osteo ◯ Rheumatoid)
- ☐ Ankylosing Spondylitis
- ☐ Post-Polio Syndrome
- ☐ Muscular Dystrophy
- ☐ Ataxia
- ☐ Morbid Obesity
- ☐ Spinal Muscular Atrophy
- ☐ Neuropathy
- ☐ Lymphedema
- ☐ Osteogenesis Imperfecta
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Epilepsy or Seizure Disorder
- ☐ Head Injury date of onset _____
- ☐ Shunt where_____ date _____
- ☐ Any other chronic medical condition _____
- ☐ Orthopedic Surgery – type and date _____
- ☐ Any bone or joint problems that limit you from engaging in physical activity – if yes specify _____
- ☐ Currently Pregnant
- ☐ Chronic Dizziness

- ☐ Amputation - Type _____ Prosthesis ◯ Yes ◯ No
- ☐ Spinal Cord Injury (date of onset)_____ ◯ Paraplegia ◯ Quadriplegia
- ☐ Blind or Low Vision
- ☐ Requires assistance with community mobility ◯ Yes ◯ No

- ☐ Incontinence of bowel or bladder
- ☐ On a bowel management program
- ☐ History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-diff, Crohn's, Colitis, etc.
- ☐ Current pressure sore(s) where _____
- ☐ Current open wound(s) where _____
- ☐ Seizure in the past 6 months date _____

Will a caregiver or family member be attending with you? ◯ Yes ◯ No

Do you use a mobility device to get around inside the home or in the community? ◯ Yes ◯ No

◯ Manual Wheelchair ◯ Power Wheelchair ◯ Walker/Rollator ◯ Cane/Crutches ◯ Other _____

List any information you would want shared with emergency personnel, including medications and allergies.

_____

LAKESHORE

Functional Ability Classification Questions

Name: _____

Vision

Do you have difficulty seeing, even if wearing glasses?

- ◯ No difficulty
- ◯ Some difficulty
- ◯ A lot of difficulty
- ◯ Cannot do at all
- ◯ Prefer not to say
- ◯ Don't know

Hearing

Do you have difficulty hearing, even if using a hearing aid(s)?

- ◯ No difficulty
- ◯ Some difficulty
- ◯ A lot of difficulty
- ◯ Cannot do at all
- ◯ Prefer not to say
- ◯ Don't know

Mobility

Do you have difficulty walking or climbing steps?

- ◯ No difficulty
- ◯ Some difficulty
- ◯ A lot of difficulty
- ◯ Cannot do at all
- ◯ Prefer not to say
- ◯ Don't know

Cognition (Remembering)

Do you have difficulty remembering or concentrating?

- ◯ No difficulty
- ◯ Some difficulty
- ◯ A lot of difficulty
- ◯ Cannot do at all
- ◯ Prefer not to say
- ◯ Don't know

Self-care

Do you have difficulty with self-care, such as washing all over or dressing?

- ◯ No difficulty
- ◯ Some difficulty
- ◯ A lot of difficulty
- ◯ Cannot do at all
- ◯ Prefer not to say
- ◯ Don't know

Communication

Using your usual language, do you have difficulty communicating, for example understanding or being understood?

- ◯ No difficulty
- ◯ Some difficulty
- ◯ A lot of difficulty
- ◯ Cannot do at all
- ◯ Prefer not to say
- ◯ Don't know