LAKESHORE

Membership Application

Personal Information

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

Employed by _____ Retired from _____ ☐ Not Employed

Are you a Veteran? ◯ Yes ◯ No Branch of Service _____

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

Emergency Contact (Name) _____ Relation _____ Phone _____

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

Referred By ◯ Member ◯ Physician ◯ Staff Name: _____
◯ Educator ◯ PT/Therapist ◯ Other _____

Primary Disability or Health Condition _____ Secondary Health Condition _____

Treating Physician (Name) _____ Phone _____ Fax _____

Membership Package Options

◯ **Standard $50/month** Access to Lakeshore Online Fitness, Lakeshore facility, classes and programs, excluding the Aquatics Center & aquatics classes

◯ **Premier $65/month** Access to Lakeshore Online Fitness, Lakeshore facility, classes and programs, including the Aquatics Center & aquatics classes

◯ **Youth & Athlete $55/month** Access to Lakeshore Online Fitness, Lakeshore facility, classes and programs, including the Aquatics Center & aquatics classes

Additional Individuals on Membership

Household members may be added: $25/adult, $20/child

Name _____ Birth Date _____ Qualifying Condition (if applicable) _____

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Please note that all applications are reviewed to ensure members meet eligibility requirements.

Proof of residency for all members is required.

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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

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Name: _____

Date of Birth: _____

Readiness Questionnaire

This questionnaire will help us guide you to programs that may be most appropriate for you. Before becoming more physically active or if your health changes, we encourage you to speak to your doctor about any recommendations, contraindications, physical limitations or restrictions you may have.

		YES	NO
1.	Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐
2.	Are you currently going to physical therapy or have active physical therapy orders from a physician?	☐	☐
3.	Do you currently have or have had any bone or joint problems, or orthopedic surgeries that might limit you from engaging in physical activity?	☐	☐
4.	Do you have arthritis, osteoporosis, or back problems?	☐	☐
5.	Do you currently have cancer of any kind? If yes, please specify.	☐	☐
6.	Do you have a heart or cardiovascular condition? (i.e. Coronary Artery Disease, Heart Failure, or a diagnosed heart rhythm abnormality)	☐	☐
7.	Do you currently have high blood pressure? If yes, do you have difficulty managing your condition with medication or other physician-prescribed treatments? ☐ Yes ☐ No	☐	☐
8.	Do you have any metabolic conditions? (i.e. Diabetes or pre-diabetes, chronic kidney disease or liver problems). If yes, do you have difficulty managing your condition with medication or other physician-prescribed treatments? ☐ Yes ☐ No	☐	☐
9.	Do you have a respiratory disease? (i.e. Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure, Emphysema) If yes, please specify. Please select from the following	☐	☐
10.	Do you have a spinal cord injury? If yes, do you have ☐ paraplegia or ☐ quadriplegia? Date of injury: _____	☐	☐
11.	Have you had a stroke? If yes, how affected? Date of injury: _____	☐	☐

		YES	NO
12.	Do you use a mobility device to get around inside the home or in the community? If yes, what type of device? ◯ Manual Wheelchair ◯ Power Wheelchair ◯ Walker/Rollator ◯ Cane/Crutches ◯ Other	◯	◯
13.	Do you have any other medical condition not listed above? If yes, please check the box(es) below that apply to your health.	◯	◯
	☐ Amputation Type: _____ Prosthesis: ◯ Yes ◯ No		
	☐ Ankylosing Spondylitis ☐ Ataxia		
	☐ Blind or Low Vision - Requires assistance with community mobility: ◯ Yes ◯ No		
	☐ Cerebral Palsy		
	☐ Epilepsy or Seizure Disorder If yes, have you had a seizure in the past 6 months? ◯ Yes ◯ No		
	☐ Head Injury - Date of Onset: _____		
	☐ Lymphedema ☐ Morbid Obesity		
	☐ Multiple Sclerosis ☐ Muscular Dystrophy		
	☐ Neuropathy ☐ Osteogenesis Imperfecta		
	☐ Parkinson's Disease ☐ Post-Polio Syndrome		
	☐ Spina Bifida ☐ Spinal Muscular Atrophy		
	☐ Other Not Listed – Specify: _____		
14.	Do any of the following apply to you: ◯ Incontinence of bowel or bladder ◯ Current pressure sore(s) ◯ On a bowel management program ◯ Current open wound(s) ◯ History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-Diff, Chron's, Colitis, etc.		
15.	In case of emergency, is there any information you would want shared with emergency personnel? (i.e. allergies, hospital preference)		
16.	Are you comfortable using the aquatics center independently and safely?	◯	◯
17.	Are you comfortable using the fitness center equipment independently and safely?	◯	◯
18.	Do you prefer to have a one-time complimentary session to get you started?	◯	◯
19.	If yes, in what area(s)? ◯ Aquatics Center ◯ Fitness Center ◯ Both		
20.	Are you interested in meeting with someone from the Recreation and Athletics department to learn more about programs offered?	◯	◯

I have fully read, understood, and completed this questionnaire. I agree that I have been encouraged by the Lakeshore Foundation staff to seek advice from my doctor before becoming more physically active, or if my health changes.

Signature: _____ Date: _____

LAKESHORE

Please choose one of these convenient payment options.

Name: _____

Frequency of Payment:

I wish to pay my membership fees: ◯ Annually* ◯ Monthly
*10% discount is applied to all annual membership payments.

Donation to Lakeshore Foundation:

Yes, I would like to add $_____to my membership fees each month to support scholarships for qualifying individuals to participate in Lakeshore Foundation programs.

Method of Payment:

◯ Credit Card (Visa or MasterCard)
◯ Debit Card (Visa or MasterCard)
◯ Bank Draft from Checking or Savings Account (U.S. Banks only)

Automatic Payment Authorization

This payment authority is to remain in full effect until 30 days after Lakeshore Foundation has received written notification from me (or either of us). I understand that termination of this agreement can only occur if all transactions are resolved and my membership account is in good standing. I understand that fees will be charged to (credit card), or debited from (debit card or bank draft) my account on the 2nd business day of the month. I agree to pay $25 for each occurrence of a failed transaction due to insufficient funds in my account.

Signature _____ Date _____

Please provide a voided check.

Do not write your bank account or credit/debit card information on this sheet.