

# MEMBERSHIP FORM-2023

MADISON SENIOR CENTER



Date: \_\_\_\_\_

## PERSONAL INFORMATION-PLEASE PRINT IN PEN

Applicant Name : \_\_\_\_\_  
Last First M.I.

Date Of Birth :          
M M D D Y Y Y Y

Status : Single Married Separated Divorced Widowed

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_

County : \_\_\_\_\_

Home Phone : \_\_\_\_\_ Cell Phone : \_\_\_\_\_

E-Mail : \_\_\_\_\_

How did you hear about us? : \_\_\_\_\_

## EMERGENCY CONTACT(S) INFORMATION

Name : \_\_\_\_\_

Name : \_\_\_\_\_

Home Phone : \_\_\_\_\_

Home Phone : \_\_\_\_\_

Cell Phone : \_\_\_\_\_

Cell Phone : \_\_\_\_\_

Relationship : \_\_\_\_\_

Relationship : \_\_\_\_\_

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MADISON SENIOR CENTER



## PAST OR PRESENT MEDICAL HISTORY: (CIRCLE ALL THAT APPLY TO YOU)

- |                             |                               |   |                                |
|-----------------------------|-------------------------------|---|--------------------------------|
| <b>Alcohol/Drug problem</b> | <b>Emphysema/COPD</b>         | <b>Liver Disease</b>                          | <b>Blood Clots</b>             |
| <b>Anemia</b>               | <b>Heart-Attack</b>           | <b>Osteoporosis</b>                           | <b>Multiple Sclerosis (MS)</b> |
| <b>Alzheimer's (ALS)</b>    | <b>Heart-Other</b>            | <b>Prostate problem</b>                       | <b>Sleep Apnea</b>             |
| <b>Arthritis</b>            | <b>Fibromyalgia</b>           | <b>Parkinson's Disease</b>                    | <b>Headaches/Migraines</b>     |
| <b>Asthma</b>               | <b>High Blood Pressure</b>    | <b>Psychiatric Disorder<br/>(Please List)</b> | <b>Hepatitis</b>               |
| <b>Atrial Fibrillation</b>  | <b>High Cholesterol</b>       | <b>Seizure Disorder</b>                       | <b>Vision Impairment</b>       |
| <b>Dementia</b>             | <b>Hypothyroidism (low)</b>   | <b>Stroke</b>                                 | <b>Vertigo</b>                 |
| <b>Diabetes</b>             | <b>Hyperthyroidism (high)</b> | <b>STD/HIV/AIDS</b>                           | <b>Balance/Fall Risk</b>       |
| <b>Cancer-</b>              | <b>Kidney Disease</b>         | <b>Other: _____</b>                           |                                |
| <b>Type: _____</b>          | <b>Other: _____</b>           |   |                                |

## MEDICATIONS: LIST PRESCRIBED & OVER-THE COUNTER MEDICATIONS.

**DRUG NAME:**

**DOSE & DIRECTIONS:**

**REASON:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**ALLERGIES:**

**PRIMARY CARE PHYSICIAN:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**THANK YOU FOR YOUR INFORMATION**

Information on this page will only be shared with EMS in an event of an emergency. The more EMS knows about your medical history the better they can serve you. All other information is for MSC records only.



**Alabama Department of Senior Services  
Title III Services  
FY23 Participant Enrollment Form**

Name of AAA (office use) \_\_\_\_\_

Name of Senior Center (office use) \_\_\_\_\_

Enrollment Date \_\_\_\_\_

**STEP 1:** Page 1 required for all programs. **STEP 2:** Nutrition programs only. **STEP 3-5:** Staff only. **ALL** information **must be updated annually.**

**PARTICIPANT INFORMATION: Please ask for assistance if needed in completing this form**

Last Name:		First Name:		MI:
Street Address:			Mailing Address (If different):	
City:	State:	Zip:	City:	State: Zip:
County:		Home Phone: ( )	Other Phone: ( )	
Email address:				
Birthdate: ___/___/___ MM DD YYYY			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Race:</b> <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> African-American/Black <input type="checkbox"/> Native Hawaiian		<input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other		<b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino
Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Dementia-related diagnosis	
Income Range: Is your gross monthly income above \$1,133? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**EMERGENCY CONTACT INFORMATION: Please provide name of a person to contact in an emergency.**

Name: _____		Relationship to participant:	
Home Phone: _____	Work Phone: _____	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Relative
Cell Phone: _____		<input type="checkbox"/> Friend	<input type="checkbox"/> Neighbor

Primary Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

**ADLs/IADLs: Do you need help with any of the following?**

		Yes	No	Comments
A D L S	Eating			
	Transferring in and out of bed or chair			
	Walking			
	Dressing			
	Bathing			
I A D L S	Toileting			
	Doing heavy housework			
	Doing light housework			
	Preparing meals			
	Shopping for personal items			
	Managing money			
	Medication management			
Using telephone				
Access to public/private transportation?				

**Statement of Confidentiality:** The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 8973], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.

**STEP 2: Nutritional Health:** Please answer the following nutrition questions for congregate, home-delivered meals, and nutrition counseling:

- (2)  Y  N 1. Have you changed the amount or kinds of food you eat because of illness or health condition?
- (3)  Y  N 2. Do you eat fewer than 2 meals a day?
- (1)  Y  N 3. Do you eat fewer than 3 fruits or vegetables a day?
- (1)  Y  N 4. Do you eat fewer than 2 servings of dairy products a day? (Milk, yogurt, cheese)
- (2)  Y  N 5. Do you have 2 or more drinks of beer, liquor, or wine almost every day?
- (2)  Y  N 6. Do you have any tooth or mouth problems that make it hard to eat?
- (4)  Y  N 7. Do you sometimes not have enough money for the food you need?
- (1)  Y  N 8. Do you eat alone most of the time?
- (1)  Y  N 9. Do you take 3 or more kinds of medicines a day? (include over the counter & prescription medicines)
- (2)  Y  N 10. Without wanting to, have you lost or gained 10 pounds or more in the past 6 months?
- (2)  Y  N 11. Do you have any physical problems that make it difficult for you to shop, cook, or feed yourself?

← **Nutrition Risk Score** of 6 or greater suggests "High" Nutrition Risk.

Y  N Do you want a referral to a Registered Dietitian Nutritionist for Nutrition Counseling?

**DO NOT WRITE BELOW THIS LINE**

**STEP 3: Nutrition Staff**

*To be completed by staff:*

**1. Approved Congregate Meals:**

- Hot Meals
- Frozen
  
- Liquid Meal Replacement
- Shelf Stable

**2. Approved Home-Delivered Meals:**

- Hot Meals
- Frozen Meals (pick up at center)
- Frozen Meals (participant delivery by vendor)
- Shelf Stable
- Breakfast
- Liquid Meal Replacement (pick up at center)
- Liquid Meal Replacement (participant delivery by vendor)

**3. To be approved for liquid meal replacement, are all requirements met, and does the Agency have a doctor's order on file?**  
 Yes  No

**4. If this participant is eligible for Title III-C Nutrition Services, identify why:**

- Age 60 and older
- Spouse of eligible participant
- Volunteers at mealtime
- Individual with disability living with eligible participant
- Individual with disability living in public, low-income housing where a senior center is located
- 60+ caregiver

Date Approved: \_\_\_\_\_ Staff: \_\_\_\_\_

**STEP 4: Notes/Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STEP 5:**

**AIMS #:** \_\_\_\_\_ **Date Entered:** \_\_\_\_\_ **Staff Initials:** \_\_\_\_\_



**WAIVER OF LIABILITY AND ASSUMPTION OF RISK  
MADISON SENIOR CENTER PHYSICAL FITNESS**

***PLEASE READ CAREFULLY***

I understand that my participation in City of Madison ("City") exercise programs, operations, and/or activities is voluntary, and that I am participating by my own free choice. I agree to participate in **Madison Senior Center Physical Fitness Activities** (the "Activities") in a responsible manner and to follow applicable rules and regulations pertaining to the Activities. In consideration of being allowed to participate, I hereby agree to assume the risks of property damage, injury, illness, or death in any way associated with my participation in the Activities. **I recognize that the program requires physical exertion that may be strenuous at times and may cause physical injury, and I am fully aware of the risks and hazards involved. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the above mentioned program. I represent and warrant that I have no medical condition that would prevent my participation in the program.**

I agree to assume full responsibility for any risks, injuries, or damage, known or unknown which I might incur as a result of participating in the Activities. Such injuries may include, but are not limited to: heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to back, injuries to foot, or any other illness or soreness, including death. I agree to release, defend, indemnify, and hold harmless the City, its officials, employees, representatives, volunteers, and agents for any and all rights and claims for damages, including attorney fees, I now, or may hereafter have, whether known or unknown, in law or in equity, and arising from or in any way connected with my participation in the Activities. I agree that the terms stated herein shall also serve as a waiver of liability and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

**I acknowledge that I have carefully read this waiver of liability and assumption of risk and fully understand that I am waiving any right that I may now or hereafter have to bring a legal action to assert any claim against the City of Madison in connection with my participation in the Activities.**

I accept the conditions printed above:

\_\_\_\_\_  
*Participant Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Participant Name*





Madison Senior Center-1282 Hughes Road- Madison, AL 35858

### **Rules and Regulations for Appropriate Behavior**

These rules and regulations are to be a guideline of what is expected of everyone while attending the Madison Senior Center. Inappropriate behavior and misconduct may result in action up to and including termination of participant eligibility rights.

**The following is appropriate conduct within the center, in city vehicles, and center-sponsored outings:**

1. Treating all staff, participants, and guests in a courteous manner.
2. Refraining from behavior and conduct that is offensive or undesirable.
3. Maintaining cleanliness and personal hygiene.
4. Respecting the property of center and others.
5. Complying with all health, safety, and security regulations.
6. Reporting to management any threatening or potentially violent behavior by staff or other participants.

**The following is prohibited conduct within the center, in city vehicles, and center-sponsored outings:**

1. Being argumentative with staff, participants, or guests of the center.
2. Not complying with rules set forth by the center director.
3. Intentionally destroying personal or center property.
4. Using language in a manner that offends, shocks, or is intended to insult.
5. Communicating any false, vicious, or malicious statements concerning the center, another person, or the organization.
6. Engaging in or threatening acts of violence, including but not limited to:
  - a. Unauthorized possession of firearms or other weapons in or around the senior center property.
  - b. Threatening or intimidating staff, guests, or participants of the center.
  - c. Hitting one's fist into the palms of hands, or on tables – intimidating behavior.
  - d. Making remarks about others in the center.

**The examples of prohibited conduct described above are not intended to be an all-inclusive list.**

At the Madison Senior Center's discretion, any violation of the center's policies or any conduct considered inappropriate or unsatisfactory will subject the participant to disciplinary action. The disciplinary action will be determined by the center director and staff and will be based upon the severity of the offense. This action could result in the participant's loss of attendance, or even permanent banishment from the center. All offenses will be documented by the center director and maintained in the client's records for future reference.



Madison Senior Center-1282 Hughes Road- Madison, AL 35858

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I, \_\_\_\_\_, the undersigned have received a copy of the Madison Senior Center Rules and Regulations for Appropriate Behavior guidelines. I have been given the opportunity to read and understand this information. If I have any questions regarding the rules and regulations after reading the guidelines, I may contact the senior center director or the county Nutrition Coordinator for clarifications.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Director's Signature

\_\_\_\_\_  
Date