ISABELLA INSTITUTE FOR OLDER ADULTS

PART A: FIFTY PLUS CLUB MEMBERSHIP INFORMATION

PERSONAL INFORMATION

☐ Ms. ☐ Mrs. ☐ Mr.	**Last Name:**	**First Name:**	**Middle Initial:**	☐ **M** ☐ **F**	**DOB:**
Mailing Address:	**Apt #:**	**Home Phone:**	**Mobile Phone:**		
City:	**State:**	**Zip Code:**	**E-mail:**		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed					**Ethnicity:**

PART B: THE FOLLOWING INFORMATION IS ONLY FOR THOSE REQUESTING TO JOIN THE EXERCISE PROGRAM
(PLEASE SKIP THIS PORTION IF YOU WILL NOT PARTICIPATE IN WALKING WORKS WONDERS)
The information in this questionnaire is strictly confidential and is intended to be used only in case of an emergency.

WE STRONGLY RECOMMEND THAT YOU CONTACT YOUR PHYSICIAN BEFORE BEGINNING ANY EXERCISE PROGRAM

WALKING WORKS WONDERS APPLICATION

Emergency Contact Full Name: _____

Relationship to you: _____

Emergency Contact Phone Number: _____

Emergency Contact Address: _____

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

PERSONAL HEALTH HISTORY

List any diagnosed medical problems:

Preferred Hospital(s) *In order of Preference*

1.
2.
3.

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies:

Additional Comments:

Liability Release:

I hereby acknowledge and agree that I have been advised to contact my physician before starting any exercise program; and that there is an inherent risk of injury or illness involved with any exercise program. I fully and voluntarily assume complete responsibility for those risks and for the injuries that may occur as a result of those risks.

Signature_ ____________________________________ **Date:**_____________________________