

MARINA SENIOR CENTER

LOCATED AT

Rocky Han Community Center (211 Hillcrest Avenue, Marina, Ca 93933)

Marina Senior Center Membership Packet

HOURS OF OPERATION

Monday thru Friday from 9:00 am to 2:00 pm

(831) 384-6009 (ph)

(831) 384-9148 (fx)

www.ci.marina.ca.us (web)

MARINA SENIOR CENTER

Membership Drive July 2015 – June 2016

Welcome to the Marina Senior Center!

We are very excited to see both new and returning members of the Marina Senior Center, located at the Rocky Han Community Center (211 Hillcrest Avenue, Marina 93933). For those of you who are not familiar with the Senior Center we would like to extend an invitation to visit, meet staff and take a tour of our facility.

The Marina Senior Center is an affordable program for all area seniors to come and enjoy all year long. It's the goal of the Recreation Staff to provide classes, events and activities that will enrich its members' way of living. With classes like yoga, tai chi and line dancing to keep the body moving to sewing and knitting classes to keep the mind sharp.

The Center is open to all area seniors ages 55yrs. and over. The Marina Senior Center doors are open Monday thru Friday from 9:00 am to 2:00 pm. We are closed on weekends and holidays.

Registration is needed to participate, membership forms are available at the Senior Center and online (www.ci.marina.ca.us). Membership forms must be turned in to the Senior Center (211 Hillcrest Avenue) with payment. Payments can be made in the form of cash or a check payable to the City of Marina.

MEMBERSHIP FEES

Memberships are valid from June to July

Resident.....	\$20.00
Non-Resident.....	\$30.00
Line Dancing (only).....	\$20.00
Yoga.....	\$2.00 per session & must be a registered member

If you have any questions on activities or events held at the Marina Senior Center please contact us by calling (831) 384-6009.

See you soon,
Marina Senior Center Staff

SENIOR CENTER REGISTRATION FORM

JULY 2015 – JUNE 2016

Confidentiality: All of the information being requested is for our records, the information you provide will be kept completely confidential. Your cooperation in providing this information is both appreciated and necessary.

PARTICIPANT'S INFORMATION

FIRST NAME	LAST NAME & MIDDLE INITIAL	NICKNAME
AGE	GENDER	DATE OF BIRTH (M/D/Y)
HOME ADDRESS		CITY & ZIP CODE
HOME NUMBER	CELL NUMBER	
LIST ACTIVITIES OF INTEREST & FAVORITE HOBBIES		
ETHNICITY (OPTIONAL) <input type="checkbox"/> African American <input type="checkbox"/> Asian American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Multi Racial <input type="checkbox"/> Other _____ _____		

EMERGENCY CONTACT INFORMATION – PRIMARY

FIRST NAME	LAST NAME & MIDDLE INITIAL	RELATIONSHIP TO YOU
HOME ADDRESS		CITY & ZIP CODE
HOME NUMBER	WORK NUMBER	CELL NUMBER

EMERGENCY CONTACT INFORMATION – SECONDARY

FIRST NAME	LAST NAME & MIDDLE INITIAL	RELATIONSHIP TO YOU
HOME ADDRESS		CITY & ZIP CODE
HOME NUMBER	WORK NUMBER	CELL NUMBER

- FOR OFFICE USE ONLY -

PAYMENT INFORMATION Amount Paid \$ _____ Receipt # _____ Date Received _____	Membership Type <input type="checkbox"/> Resident <input type="checkbox"/> Non-Resident <input type="checkbox"/> Line Dancing / Yoga
FORMS SUBMITTED <input type="checkbox"/> Participant's Waiver, Release, Assumption of Risk & Indemnity Agreement <input type="checkbox"/> Medical Information & Consent to Medical Treatment <input type="checkbox"/> Other _____	
KIDS TRACK SYSTEM Date Entered _____ Entered By _____	
SPECIAL NOTES _____ _____	

PARTICIPANT ACKNOWLEDGEMENT & COMMITMENTS*Participants Initials*

I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO SIGN IN AND OUT OF THE MARINA SENIOR CENTER.	
I ACKNOWLEDGE THAT THE CITY OF MARINA DOES NOT PROVIDE TRANSPORTATION TO AND FROM THE CENTER.	
I ACKNOWLEDGE THAT THE CITY OF MARINA IS NOT HELD RESPONSIBLE FOR ANY PERSONAL PROPERTY THAT MAY BECOME DAMAGED OR MISSING.	
I ACKNOWLEDGE THAT ANY INAPPROPRIATE BEHAVIOR UPON MY BEHALF COULD PUT MY MEMBERSHIP AT RISK.	
I ACKNOWLEDGE THAT THE CITY OF MARINA HAS THE RIGHT TO SEARCH AND SEIZURE AND WILL BE ONLY PRACTICED WHEN STAFF BELIEVES THE HEALTH & SAFETY OF STAFF, VOLUNTEERS AND OR MEMBERS ARE IN JEOPARDY.	
I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO REGISTER FOR FIELD TRIPS IN PERSON AND THAT IT IS NOT THE RESPONSIBILITY FOR STAFF TO CALL WITH A REMINDER.	
I ACKNOWLEDGE THAT I AM INVITED TO ATTEND THE SENIOR CENTER ADVISORY MEETINGS, WHICH ARE HELD EVERY 2 ND TUESDAY OF THE MONTH, TO VOICE MY COMMENTS AND SUGGESTS FOR THE SENIOR CENTER.	
I AM COMMITTED IN HAVING AN OPEN COMMUNICATION RELATIONSHIP WITH THE STAFF, VOLUNTEERS & MEMBERS OF THE CENTER.	
I AM COMMITTED IN TREATING ALL STAFF, VOLUNTEERS & PARTICIPATING MEMBERS WITH RESPECT AT ALL TIMES.	
I AM COMMITTED IN REPORTING ANY CHANGES IN INFORMATION THAT HAS BEEN ASKED IN THESES FORMS.	
I AM COMMITTED IN ARRIVING ON TIME AND HAVING POSITIVE ATTITUDE FOR SCHEDULED FIELD TRIPS.	
I AM COMMITTED IN PROVIDING CONSTRUCTIVE FEEDBACK TO STAFF OF THE MARINA SENIOR CENTER.	

I, THE PARTICIPANT, UNDERSTAND THAT BY SIGNING THIS MEMBERSHIP APPLICATION, I WILL FOLLOW ALL RULES AND REGULATIONS SET FORTH BY THE CITY OF MARINA RECREATION & CULTURAL SERVICES DEPARTMENT. I FURTHER UNDERSTAND THAT IF A STAFF MEMBER OR A VOLUNTEER OF THE CITY OF MARINA SEES ME DOING ANYTHING UNSAFE OR INAPPROPRIATE EITHER IN OR AROUND THE VICINITY OF THE RECREATION CENTER, I WILL BE CORRECTED ON MY BEHAVIOR. I ALSO UNDERSTAND THAT VIOLATING THE RULES AND REGULATIONS OF THE CENTER OR INAPPROPRIATE CONDUCT MAY RESULT IN SUSPENSION OF MY MEMBERSHIP.

 Print Name

 Signature of Applicant

 Date

**NOTE: Must complete Participant Waiver & Medical Release Form in its entirety prior to participation.*

CITY OF MARINA PARTICIPANT WAIVER FORM

Name of Participant

Last

First

Middle Initial

PARTICIPANT'S RELEASE WAIVER, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

In consideration of the acceptance of the application, as a participant in any programs and/or activities of the City of Marina, I hereby agree to assume all risks attendant upon myself while participating in any City of Marina programs and/or activities. I acknowledge the following: that participation in this event is voluntary, and involves physical activity. I agree as to myself and for my heirs, personal representatives or assigns, to hereby assume the risk of any injury from any cause whatsoever, including the negligence of the City; and to give up, waiver, and discharge and release the City of Marina, the Corporate Sponsors of this program, their officers, volunteers, agents, and employees, from any and all claims for injuries, including death, and I agree to hold the City harmless, and covenant not to sue the City or others listed herein, should property loss, injury, or death occur during or as a result of my participation in this program. If necessary, the City may provide medical care at my expense. By signing below, I acknowledge that I have read this assumption of risk, waiver and release of liability agreement, fully understand its terms, and I understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing this agreement freely and voluntarily, and intend by my signature for this to be a complete and unconditional release of all liability to the greatest extent of the law I hereby waive, release, and discharge any and all claims for damages for death, personal injury, or property damage which I may have, or which may hereafter accrue to me, as a result of my participation in the City of Marina program or activity. I agree to indemnify and hold harmless from liability the City of Marina.

I acknowledge that I have read the Release Waiver, Assumption of Risk and Indemnity Agreement and sign it on behalf of the participant with full knowledge and understanding of its contents.

Print Name

Signature

Date

VIDEO-PHOTO RELEASE

I understand that during the City of Marina program and/or activity, my photograph may be taken by the City of Marina, producers, sponsors, organizer, and/or assigns. I agree that my photograph, including video photography, film photography, or other reproduction of my likeness, may be used without charge by the, producers, sponsors, organizers and/or it's assigns for such purposed as they deem appropriate.

I acknowledge that I have read the Video-Photo Release and sign it on behalf of the participant with full knowledge and understanding of its contents.

Print Name

Signature

Date

CITY OF MARINA MEDICAL RELEASE FORM

PARTICIPANT'S MEDICAL INFORMATION - Confidentiality: All of the information being requested is for our records, the information you provide will be kept completely confidential. Your cooperation in providing this information is both appreciated and necessary.

PARTICIPANT'S INFORMATION

FIRST NAME	LAST NAME	MIDDLE INITIAL
AGE	GENDER	DATE OF BIRTH (M/D/Y)

PARTICIPANT'S MEDICAL INFORMATION

DOCTOR/PRACTITIONER'S NAME	DOCTOR/PRACTITIONER'S PHONE NUMBER
INSURANCE CARRIER	POLICY NUMBER

PARTICIPANT'S MEDICAL INFORMATION

ARE YOU A DIABETIC?	YES ____	NO ____	IF YES, LIST MEDICATIONS AND OR DIET PLAN
ARE YOU SUBJECT TO SEIZURES OF ANY KIND?	YES ____	NO ____	IF YES, EXPLAIN
DO YOU HAVE ANY ALLERGIES INCLUDING FOOD, MEDICATIONS AND DRUG REACTIONS?	YES ____	NO ____	IF YES, EXPLAIN
ARE YOU CURRENTLY UNDER ANY MEDICAL TREATMENT / CARE?	YES ____	NO ____	IF YES, EXPLAIN
DO YOU HAVE A HISTORY OF RESPIRATORY ILLNESS?	YES ____	NO ____	IF YES, EXPLAIN
DO YOU WEAR A HEARING AID OR HAVE HEARING PROBLEMS?	YES ____	NO ____	IF YES, EXPLAIN
DO YOU SUFFER FROM FAINTING SPELLS?	YES ____	NO ____	IF YES, EXPLAIN
DO YOU HAVE HEART TROUBLES?	YES ____	NO ____	IF YES, EXPLAIN
DO YOU HAVE ANY DISABILITIES OR DISORDERS	YES ____	NO ____	IF YES, EXPLAIN
ARE YOU AN ORGAN RECIPIENT OR DONOR?	YES ____	NO ____	IF YES, EXPLAIN

PARTICIPANT'S MEDICATION LIST

PLEASE LIST ALL CURRENT MEDICATIONS.
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black;"/>

PARTICIPANT'S HEALTH CONCERNS

ANY OTHER RESTRICTIONS OR OTHER HEALTH CONCERNS STAFF SHOULD BE AWARE OF? IF YES PLEASE EXPLAIN.
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black;"/>

CITY OF MARINA MEDICAL RELEASE FORM (part II)

Name of Participant

Last

First

Middle Initial

PARTICIPANT'S MEDICAL RELEASE AGREEMENT

While I am attending or traveling to or from the Marina Senior Center, I hereby authorize the staff member, or in his/her absence or disability, any adult accompanying or assisting him/her, to consent to the following medical treatment for me should I be unable to make a decision:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed, under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until I complete my activities in this program unless revoked in writing. I understand that I will be responsible for the cost of any service or treatment provided.

AUTHORIZATION AND CONSENT AND RELEASE

I hereby certify that I am in good health and can travel to and participate in all functions of the City of Marina Senior Center Program as described above. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting staff at the Marina Senior Center.

Print Name

Signature

Date

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit me from receiving any non-life threatening medical attention in the event of an accident or illness.

Print Name

Signature

Date