

Hunterdon County Division of Senior, Disabilities & Veterans Services

Senior Center – Fee Based Physical Activity Registration Form

4 Gauntt Place, PO BOX 2900

Flemington NJ 08822

908-788-1359



**Personal Information**

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

Address: \_\_\_\_\_  
Street Address Apartment/Unit #

\_\_\_\_\_  
City State ZIP Code

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Please be aware that the lists maintained by DSDVS are considered public records and pursuant to the Open Public Records Act (OPRA) are subject to disclosure under NJSA 47A:1A-1 et seq**

**Emergency Contact Information**

\_\_\_\_\_  
Last First M.I.

Daytime Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

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

**CLASS REGISTRATION**

Class Name	Instructor	Day

Exercise cards can be used for any type of exercise. Card's come in increments of 4 sessions, 8 sessions and 12 sessions.

Number of Cards	Total Due
X	
X	

For staff use only:

Punch card number	Date	Amount Received	Wavier Mailed with Card

Staff initials \_\_\_\_\_

**Division of Senior, Disabilities and Veterans Services**  
**Senior Health and Fitness Program**  
**Release/Waiver of Liability**

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Email address: \_\_\_\_\_

Home Address \_\_\_\_\_

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

Class(s) enrolled in: \_\_\_\_\_

1. I am signing this Release/Waiver for the purpose of participating in this Hunterdon County Senior Health and Fitness program. Participating in this activity involves certain risks. I am signing this to acknowledge that I understand those risks and agree to assume them. *The following fitness programs include: Sumba, Jive, Aerobics, Yoga, Chair Yoga, Tai Chi, Meditation, Gentle Exercise. Also the HealthEASE: Move Today, Getting Stronger, Healthy Bones, Tai Chi for Arthritis and Matter of Balance.*
  
2. I understand that the participation in Physical Activity poses a risk of injury. It place undo stress on the body and its various parts and systems. I am physically fit and capable of participation in these activities/classes and know of no medical condition which would prevent me from participation or might be worsened by my participation. I have been advised to consult with my physician if I have any questions to my physical ability, or reservations about my participation. I understand that my physical and medical conditions may change from time to time, and that I am advised to consult my own personal physician periodically to reevaluate my condition.

I agree to:

- a. Access my physical and medical condition before participating in any activity.
  - b. Consult with my personal physician if I have any questions about my ability to participate.
  - c. Follow directions given by the program instructor/leader
  - d. Notify the leader if I see a dangerous condition or if I feel ill.
  - e. Wear appropriate footwear/clothing
3. I understand that I must maintain my own health insurance or other insurance to pay For any injuries to myself while on the premises and participating in the Senior Health and Fitness program. I understand that the County will NOT be responsible for my medical expenses.
  4. I understand that participating in this Health and Fitness activity/class I risk being hurt or insured. I have freely assumed those risks since I want to participate. I will not hold the instructor/leader or Senior Health and Fitness, the Division of Senior, Disabilities and Veteran Services, the County of Hunterdon, or any of their agents or employees responsible for any injuries or medical expenses that result from my participation in any Senior Health and Fitness program.

5. I understand I am solely responsible for the use of handouts or exercise times used outside of class, and no one, except me, can be held responsible for the use of same.

*Please sign and date this form and make sure your name is printed on the top.*

*\*\* Complete the information on the reverse side as well.*

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

*Name of person or doctor to contact in case of emergency that has knowledge of my medical conditions or prescriptions.*

*Emergency Contact Number: \_\_\_\_\_*

*Any additional information you feel the instructor should know:*

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***Please be aware that your Leader is directed to call 911 if She/He feels the situation calls for emergency assistance.***

***Witness: \_\_\_\_\_ Date: \_\_\_\_\_***

## Statement of Medical Clearance for Exercise

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

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

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

The above named patient would like to participate in the following exercise classes:

\_\_\_\_\_

The patient will complete a waiver of Liability.

\_\_\_\_ YES, my patient has no current unstable medical problems that are a  
contraindication to participating in these exercise programs. I approve and  
support his/her participation in this exercise regimen.

Have you ever place any restriction on this patient's physical activity? Yes/No

If YES

(describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ NO, my patient is not eligible to participate in these exercise program due to his/her  
current medical status

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

Physicians Information:

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

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

Telephone: \_\_\_\_\_

If you would like to know more about these exercise programs; contact Eleanor  
Langeveld at Senior Health & Fitness Program: (908) 284-6128

Revised: EL: 11/15/2012