



A TURNING POINT  
FOR WOMEN

## Health and Wellness Membership Form

- General**
 **Adult**
 **Family**  
 **Women's Health Club**
 **Senior**  
 **Youth (12-17)**  
 **Student (18+)** (*copy of student card attached*)

Member Start Date: \_\_\_\_\_ Locker # \_\_\_\_\_

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

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Birth date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Lethbridge AB, { \_\_\_\_\_ }  
Other City if Applicable

Postal Code: \_\_\_\_\_ Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Telephone #: \_\_\_\_\_

Medical/Caution Information: \_\_\_\_\_

Permission to take photos for advertising purposes: Yes \_\_\_\_\_ No \_\_\_\_\_

**OPTIONAL:** For statistical purposes only, please check if you are  
Aboriginal \_\_\_\_\_ Member of a visible minority \_\_\_\_\_ Person with a disability \_\_\_\_\_

### Family Names and Ages for Swim Pass Purposes Only

Name: \_\_\_\_\_ Birthdate: Y\_\_\_\_ M\_\_\_\_ D\_\_\_\_ Gender: M\_\_\_\_ F\_\_\_\_

Name: \_\_\_\_\_ Birthdate: Y\_\_\_\_ M\_\_\_\_ D\_\_\_\_ Gender: M\_\_\_\_ F\_\_\_\_

Name: \_\_\_\_\_ Birthdate: Y\_\_\_\_ M\_\_\_\_ D\_\_\_\_ Gender: M\_\_\_\_ F\_\_\_\_

The YWCA respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to protecting privacy. We collect your personal data in order to better meet your program, services, or information needs. We do not rent or sell any personal information. We will not disclose your personal information to anyone else without your prior knowledge and written consent, except when required by a government body or agency, or as permitted by law. All YWCA staff having access to your personal data are required to respect the confidentiality of personal data and handle personal information responsibly. All personal data will be maintained on file for a period of seven years and then destroyed/disposed of by an authorized staff member.

# PAYMENT TERMS

**Memberships will be cancelled immediately if any payments are declined.**

Payment in Full

Post-Dated Visa

Post-Dated MasterCard

Pre-Authorized Bank Debit

*Attach void cheque or void credit card imprint at time of purchase.*

Account Holder Name: \_\_\_\_\_

## **Bank Debit**

Transit/Branch Number: \_\_\_\_\_ Institute Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

## **Post-Dated Credit Card**

Credit Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**Signature of Account Holder:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### TO BE COMPLETED BY FRONT DESK STAFF

1<sup>st</sup> Payment \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Family Membership  
Additional Family members: \_\_\_\_\_

15% Corporate Discount  
(Letter of employees must be attached)

PAP date:  15<sup>th</sup> of the month  25<sup>th</sup> of the month

Card # \_\_\_\_\_ Card expiry: \_\_\_\_\_

**Front Desk Signature:** \_\_\_\_\_

### CARD RENEWAL

Today's date: \_\_\_\_\_ Expiry date: \_\_\_\_\_ Discount: \_\_\_\_\_

Today's date: \_\_\_\_\_ Expiry date: \_\_\_\_\_ Discount: \_\_\_\_\_

Today's date: \_\_\_\_\_ Expiry date: \_\_\_\_\_ Discount: \_\_\_\_\_

**1-3 years 10%      3-5 years 15%      5+ years 20%**  
**(No discount on renewing student memberships)**

**Circle the appropriate response for each of the following questions:**

- Yes No Has your doctor said that you have a heart condition and recommended only medically approved physical activity?  
If yes, explain \_\_\_\_\_
- Yes No Do you have chest pain brought on by physical activity?  
If yes, explain \_\_\_\_\_
- Yes No Have you developed chest pain, at rest, in the past month?  
If yes, explain \_\_\_\_\_
- Yes No During physical exertion do you lose consciousness, become light-headed or lose your balance?  
If yes, explain \_\_\_\_\_
- Yes No Do you have a bone or joint problem that could be aggravated by the proposed physical activity?  
If yes, explain \_\_\_\_\_
- Yes No Is your doctor currently prescribing medication for your blood pressure or heart condition, or any other type of medication? (e.g. diuretics or water pills)  
If yes, explain \_\_\_\_\_
- Yes No Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval?  
If yes, explain \_\_\_\_\_
- Yes No Have you abstained from exercise for the last 6 months due to illness, trauma or surgery?  
If yes, explain \_\_\_\_\_
- Yes No Have you recently experienced any shortness of breath or chest pain with exertion?  
If yes, explain \_\_\_\_\_
- Yes No Do you currently have any medically related exercise restrictions?  
If yes, explain \_\_\_\_\_
- Yes No Are you pregnant? What month are you in? \_\_\_\_\_
- Yes No Have you been newly diagnosed with any medical conditions such as high blood pressure or diabetes?  
If yes, explain \_\_\_\_\_

**If you answered "Yes" to any of the above questions, consult with your physician and a YWCA health and fitness coordinator before increasing your physical activity. Tell him/her which questions you answered "Yes" to.**

**Note:**

1. If you have a temporary illness, such as a fever, or are not feeling well at this time, you may wish to postpone the proposed activity.
2. If you are pregnant, you are advised to discuss the “PAR-X for pregnancy” with your physician before exercising.
3. If there are any changes in your status relative to the above questions, please bring this information to the immediate attention of your fitness professional.
4. If you are at high risk or if you have a limiting physical condition you may be required to have your Health Care Professional fill out a “YWCA-request for information form.”
5. The YWCA reserves the right to refuse membership to anyone.

**WAIVER** – I realize that it is my responsibility to secure the recommended doctor’s approval; to wear appropriate footwear and clothing; and that use of the equipment and facility is at my own risk and not the responsibility of the YWCA Lethbridge and District. I have volunteered to participate in a program of progressive physical exercise. I waive any possibility of personal damage which may be blamed upon such a program in the future and accept the responsibility for requesting such exercise assistance. The possibility of certain unusual changes during exercise does exist. They include: abnormal blood pressure, fainting, disorders, irregular heartbeat and very rare instances a heart attack. Every effort will be made to minimize them by preliminary examination and by observations during situations which may arise. I hereby acknowledge and accept these risks. To the best of my knowledge, I do not have any limiting physical condition or disability which would prohibit an exercise program.

**MEMBERSHIP POLICIES**

- Continual memberships are **renewed automatically**.
- Membership cancellation requires **ONE MONTH’S WRITTEN NOTICE**. No refunds will be applicable for the balance of the current month. \$10.00 cancellation fee applies.
- The above information allows the Lethbridge YWCA to debit my account until I cancel my membership or put on hold.
- I authorize the Lethbridge YWCA to use personal information on this form for YWCA purposes only.

**Participant’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(if under the age of 16 years)

**Health and Wellness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*“Those who think they have not time for bodily exercise will sooner or later find time for illness.”  
- Edward Stanley*