

## **One Week Gym Guest Pass**

Heated pool, indoor track, free weights, bikes,  
treadmills, ellipticals, cable cross over,  
50 aerobics classes/week, massage, Personal  
Training, nutrition consults and more!

Gym hours:  
Monday - Friday: 5:30 a.m. - 9 p.m.  
Saturday: 8 a.m. - 4 p.m.  
Sunday 11 a.m. - 5 pm.

Parking is validated

2665 N. Decatur Road, Decatur, 30033; 404.501.2222  
Guest must present this coupon to redeem it; guest passes are for new members only;  
“one week” is 7 consecutive days; all Wellness Center rules apply.



**DeKalb Medical**



DeKalb  
Medical

*Pushing Beyond*

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**Membership Application (Please Complete for Free Week Pass)**

## **The Wellness Center**

**2665 N. Decatur Road, Suite 10  
Decatur, GA 30033  
404.501.2222**

**Dear New Member:**

**As we are unable to accept emailed or faxed applications please print off this application form, complete it then bring it with you when you enroll at The Wellness Center.**

**Thank you.**

***Don't forget to bring a towel and a lock for your locker!***



## Membership Choices – check one

(Continued on next page)

**PLEASE READ MEMBERSHIP INFORMATION AT BOTTOM OF NEXT PAGE**

### **Guest Passes**

- Free One Week
- One Week Guest Pass \$20
- 1 day pass: \$10
- 2 week pass: \$30

### **General Memberships (ages 16 to 59)**

- 1 month: \$44
- 6 months: \$238
- 6 month Bank Draft: \$39.66 / month
- 12 months: \$423
- 12 month Bank Draft: \$35.25 / month

### **General Membership 2<sup>nd</sup> Household Member Discount**

- 6 months: \$226
- 6 month Bank Draft: \$37.66 / month
- 12 months: \$383
- 12 month Bank Draft: \$31.91 / month

### **Senior Discounts (ages 60 and older)**

- 1 month: \$38
- 6 months: \$204
- 6 month Bank Draft: \$34.00 / month
- 12 months: \$365
- 12 month Bank Draft: \$30.41 / month

### **Senior Discount 2<sup>nd</sup> Household Member**

- 6 months: \$194
- 6 month Bank Draft: \$32.33 / month
- 12 months: \$330
- 12 month Bank Draft: \$27.50 / month

### **Specialty (only taking “Easy Motion”)**

- 1 month \$27

**Membership Choices**  
(continued)

**Employee Discounts**

- payroll deduction: \$14.00 / pay period (6 month contract)
- 1 month: \$36
- 6 months: \$161
- 12 months: double \$158 \$322
- 6 month Bank Draft: \$26.83 / month
- 12 month Bank Draft: \$26.83 / month

**Employee Household Member Discount**

- 1 month: \$40
- 6 months: \$214
- 6 month Bank Draft: \$35.66 / month
- 12 months: \$383.
- 12 month Bank Draft: \$31.91 / month

**DeKalb County School System - Decatur City Schools- DeKalb County Government - City of Decatur - and SouthCare - Coventry\*\***

- 1 month: \$40
- 6 months: \$214
- 6 month bank draft: \$35.66 / month
- 12 months: \$383
- 12 month bank draft \$31.95 / month

- Silver Sneakers
- Workers' Comp

***Membership information. If you have questions please speak with a staff member.***

- When you apply for a discounted membership, you will be asked to complete a discount verification form. Eligibility for discounts will be verified each time you renew your membership.
- All bank draft memberships carry a penalty if voided before expiration date.
- Membership by payroll deduction may be terminated after six consecutive months of membership; a signed termination form must be submitted.

CONSENT AND RELEASE

I have voluntarily enrolled at The Wellness Center at DeKalb Medical in either a structured exercise program or a program which permits self-directed recreational use of exercise facilities.

I have been informed and understand that there are certain risks of accident, illness, injury, or death that are inherent in any program of physical exercise. These risks include, but are not limited to, increased pulse and respiration rate, joint stress on weight bearing joints, fatigue, possible blood pooling which can cause fainting, sore and/or pulled muscles, side cramps and charley-horses, and dehydration, as well as less common risks such as broken bones and heart failure.

I further understand these risks can be intensified and possibly become severe in participants with certain high risk factors identified as high blood pressure, obesity, diabetes, high blood fat levels, heavy intake of alcohol, heavy cigarette use, history of heart disease, and history of joint disease-- especially back and knee disorders.

I have been informed and understand that The Wellness Center has no responsibility to detect factors that may increase the risk of illness or injury for particular participants in its exercise program and that it urges each participant to consult his/her physician before beginning an exercise program. By signing below, I consent to assume all risks, which are associated with, or which may result from, vigorous physical exercise or any other activities I undertake in structured programs or recreational activity conducted by The Wellness Center.

In consideration of the benefits I will receive from The Wellness Center exercise program I, for myself and my heirs, executors, and assigns, release The Wellness Center, DeKalb Hospital Authority, DeKalb Medical, Inc., and their officers, agents, staff, physicians, and other representatives from any and all liability for illness, injury or death which may occur from, or arise out of, participation in the exercise program, from any cause whatsoever, including the negligence of those being released.

If one or more of the provisions contained herein shall be held to be unenforceable in any respect under Georgia law, such unenforceability shall not effect any other provision of this Consent and Release. The Consent and Release shall then be construed as if such unenforceable provision or provisions had never existed.

PRINT YOUR NAME \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness (Wellness Center staff) \_\_\_\_\_

Date \_\_\_\_\_

## Health History Survey

Please answer the following questions so that we may better understand your personal health and fitness status. **Certain health conditions may require that we contact your physician for clearance.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

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

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

Age: \_\_\_\_\_ Date of birth (mm/dd/yyyy): \_\_\_\_\_

Name of your personal physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_  Male  Female

Physician's Address: \_\_\_\_\_

Please list all medications you take regularly:

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**No    Yes**

		Have you ever had a stroke?
		Have you ever had a coronary bypass surgery or any other type of heart surgery?
		Do you have any other cardiovascular or pulmonary (lung) disease (other than asthma, allergies or mitral valve prolapse)
		Have you ever been told by a health professional that you have an abnormal resting or stress electrocardiogram (EKG)?
		Have you ever experienced rapid heart action or palpitations that required medical attention?

		Have you ever had angina pectoris or sharp pain or heavy pressure in your chest as a result of exercise, walking or other physical activity, such as climbing a flight of stairs?
		Has a doctor ever said you have a heart condition and recommended only medically supervised physical activity?

Do you have a history of:  Diabetes  Thyroid  Kidney  Liver disease

If you checked any of the above questions, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you currently have any of the following?

**No Yes**

<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Unexpected dizziness or fainting
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the ankles (recurrent and unrelated to injury)
<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations (irregularity or racing of the heart on more than one occasion)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in the legs that cause you to stop walking (claudication)
<input type="checkbox"/>	<input type="checkbox"/>	Known heart murmur other than mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Have you discussed any of the above with your personal physician? If yes, please describe below.

If you checked any of the above questions, please describe

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**No Yes**

<input type="checkbox"/>	<input type="checkbox"/>	Within the past 12 months, has a health professional told you that your blood cholesterol was greater than or equal to 240 mg/dl or that your LDL cholesterol was greater or equal to 160?
<input type="checkbox"/>	<input type="checkbox"/>	Have two or more blood relatives had a heart attack or heart disease prior to age 55?
<input type="checkbox"/>	<input type="checkbox"/>	Has a doctor ever recommended medication for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	Currently, do you have high blood pressure?
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently smoke cigarettes?
<input type="checkbox"/>	<input type="checkbox"/>	Is there any additional health information (i.e., knee or back problems, etc.) that may be helpful to us?

If you checked any of the above questions, please describe

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

**For Wellness Center Staff Only**

<input type="checkbox"/> CSU	<input type="checkbox"/> FA	Clearance Needed
<input type="checkbox"/> TFP	<input type="checkbox"/> Ex. Consult	Form sent on: _____
<input type="checkbox"/> No Appt	<input type="checkbox"/> WLP	Form received on: _____



DeKalb Medical

**The Wellness Center**

**PHYSICIAN CLEARANCE FOR EXERCISE**

**Client:**

**Complete this section only. ---->**

**Please print.**

I authorize my attending physician

(name) \_\_\_\_\_  
to provide sufficient information to clear me for participation in my exercise program.

Client name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Your phone: \_\_\_\_\_

Your signature

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

To: Physician's Name \_\_\_\_\_

Fax Number \_\_\_\_\_ Phone \_\_\_\_\_

From: The Wellness Center @ DeKalb Medical  
2665 N. Decatur Rd., Suite 10 ~ Decatur, GA 30033  
Phone: 404.501.2222 ~ Fax: 404.501.3685

**Your patient named above requires your clearance to participate in an exercise program at the Wellness Center**

Please complete BOTH sections	Please complete BOTH sections
<u>Aerobic/Cardiovascular Training:</u> <input type="checkbox"/> My patient may participate <input type="checkbox"/> My patient may <b>not</b> participate  Explain: <input type="checkbox"/> Less than 85% of their Maximum age-predicted heart rate. <input type="checkbox"/> Water aerobics/exercises <b>only</b> <input type="checkbox"/> Other: <input type="checkbox"/> My patient <b>must see me</b> for clearance.	<u>Strength Training:</u> <input type="checkbox"/> My patient may participate <input type="checkbox"/> My patient may <b>not</b> participate  Explain: <input type="checkbox"/> Light weights with high repetitions <b>only</b> . <input type="checkbox"/> Other: <input type="checkbox"/> My patient <b>must see me</b> for clearance.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician: Please return via fax to The Wellness Center at 404-501-3685.**