



Senior Citizens Association Membership Application

Leatherman Senior Center
600 Senior Way
Florence, SC 29505
(843) 669-6761

Lake City Senior Center
198 N. Acline Street
Lake City, SC 29560
(843) 394-2432

Annual _____ Lifetime _____ New Member _____ Renewal _____

Member Information

First Name _____ MI _____ Last Name _____

Date of Birth _____ Gender: Male Female

Address _____ County _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail _____

Ethnic Group (Optional, but does assist with potential funding) : African-American _____
Asian _____ Hispanic _____ Caucasian _____ Native American _____ Other _____

Emergency Information

Name _____ Relationship _____

Phone _____ Alternate Phone _____

Volunteer Opportunities

SCA partners with the Retired Senior & Volunteer Program (RSVP), providing a variety of meaningful volunteer opportunities for senior citizens 55 and older. If you are interested in exploring how you can utilize your experience and talents in our community, please complete the following:

Yes! I am interested in volunteering

Prior Work/Career Experience: _____

Interests: _____

MEMBERSHIP AGREEMENT:

- I agree and understand that the Membership Fee that I paid is non-refundable and non-transferable.
- I understand that I will participate in Senior Center programs and activities at my own risk. Programs at the Senior Center are developed specifically for and marketed to seniors. In accepting membership I also understand that I waive, release, indemnify and hold harmless the Senior Citizens Association, Leatherman Senior Center, Lake City Senior Center, City of Lake City, Florence County, Vantage Point and its officers and employees from any liabilities, claims, damages, injuries, losses, and expenses including reasonable attorneys fees and cost whatsoever, including those for personal injury, death, or property damage, which may arise from or in connection with participation in programs, classes and/or events.
- I am aware of the limitation(s) my general health may place on performing certain activities and/or exercise of a rigorous nature and that it is my responsibility to seek medical assistance prior to participating in activities and at any time should the need arise.
- I agree and understand that the Senior Center and any other entities associated with the center are released from liability in connection with medical treatment and unavoidable incidents. I give the center permission to use necessary measures in the event of an emergency.
- I understand completion and upkeep of the Medical Form is not required but is recommended. If completed, I am giving permission to release my medical information to EMS and/or other medical personnel for medical reasons. If I choose to not provide my medical information, the Senior Center and any other entities associated with the center are not held liable.
- I understand that there is a \$5.00 fee for replacement of my membership card or name-tag.
- I understand that my membership will expire annually on my member anniversary date. All members are asked to complete the Membership Application, Agreement and Medical Form annually.
- I give Senior Citizens Association permission to use my photograph for purposes of public relations.

I have read this agreement. I understand all information and I agree to the conditions stated above.

Signature: _____ Date: _____



Senior Citizens Association Medical Form

My Medication Record as of: _____

Name: _____ Birth Date: ____/____/____

Allergies: _____

If you are currently taking any medication, please list below.

Medication Name	What is it for?	Dose	How Often	Prescribed by: (Phone number)
Aspirin	Headache	200mg	Once per day	Dr. John Doe 123-456-7890

HEALTH PROBLEMS: (CHECK ALL THAT APPLY)

____ Heart/Circulation ____ Diabetes ____ High Blood Pressure

____ Alzheimer's/Memory Loss ____ Kidney/Liver ____ Cataracts/Glaucoma

____ Stroke ____ Osteoporosis ____ Arthritis

____ Breathing/Respiratory ____ Asthma ____ Cancer

____ Other (please list): _____

Completion and updating of the Medical Form is not required, but is recommended. All information is kept confidential and is only released to emergency personnel/health care providers in the event of an emergency. It is your responsibility to keep medical information up to date. Please make sure to notify us if there are any changes to your medications &/or health.