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. **Please make checks payable to SCA.**
- 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 indemnity 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.
- 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/video for purposes of public relations and/or advertisement.
- I am aware of and understand that SCA has a code of conduct, as it relates to the senior centers programs and activities and I agree to abide by the code at all times.

I have read the Membership Agreement and the Eligibility to Attend. I understand all information and I agree to the conditions stated in both documents.

Signature:_______________________________________ Date:_____________________

For Office use only: Receipt Number:_________________Amount________Ck No.________Cash_______M.O._________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 and update your file if there are any changes to your medications &/or health.