St. Mark UMC Activity Center Membership Form

Date: _______________

Personal Information

Name: ____
Last First Middle Initial

Address: __________________________ City: ____________ State: ___ Zip: ________

Home Phone: __________________

E-mail: _________________________ (optional; for electronic notifications)

Membership Payment Options

All non-members of St. Mark UMC must pay membership or usage fees. Usage fees are due when you use the facility.

Are you a member of St. Mark UMC? *Yes ___ No___
*You are not required to pay Membership or Usage fees.

Do you use the A.C. twice or more a week? *Yes___ No___
*It may benefit you to use the $15 per month Membership payment option.

Do you use the A.C. less than twice per week? *Yes___ No___
*It may benefit you to use the $2 per visit Usage payment option.

Activity Center Rules

1. Sign in everyday you use the Christian Activity Center. This helps with monitoring payment and usage.
2. No food and drink allowed on gym floor or racquetball court.
3. No slam dunking or hanging on rims/nets.
4. No one under 16 allowed to use any exercise equipment unless accompanied by an adult 18 years or older.
5. Bring towel when using exercise equipment to wipe sweat off of the machines.
6. Use collars on weight bars and dumbbells.
7. Replace all equipment to the spot you got it from after use.
8. No swearing, taunting or rough play.
9. Treat others as you wish to be treated.
10. Help keep the CAC clean.

Membership Agreement

I agree to abide by the rules stated. I understand that any violation of the stated rules will result in a review and possible revocation of membership and usage privileges. I also agree to abide by the payment rules. Any violation could result in my revocation of usage privileges.
Signature: _________________________________ Date: _________________

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which you are subject and of which the staff should be aware. Submit this notification in writing and attach it to this form.
Note: If you take medication, please have that information accessible so that, in the case of emergencies, medical personnel may be made aware.
Check the following areas of concern. If necessary, add another page with details:

1. Do you have allergies to—
   - ❑ pollens ❑ medications ❑ food ❑ insect bites
   - Specify: ____

2. Do you suffer from, or have you ever experienced, or are you being treated currently for any of the following:
   - ❑ asthma ❑ epilepsy / seizure disorder ❑ heart trouble ❑ diabetes
   - ❑ frequently upset stomach ❑ physical handicap

3. Date of last tetanus shot: ___________________________

4. Do you wear ❑ glasses ❑ contact lenses

5. Please list and explain any major illnesses you have experienced that emergency personnel would need to know about:

Liability Agreement

Note: The term "Church" will refer to St. Mark United Methodist Church, 6795 Whitesville Rd., Columbus, GA 31904

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal loss.

I understand that there are inherent risks involved in any ministry or athletic event, and I hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my involvement. In the event that I am injured and require the attention of medical personnel, I consent to any reasonable medical treatment as deemed necessary by a licensed physician, registered nurse or emergency medical personnel. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider.

Signature: ____ Date: ___________________

Printed Name: ____

Do you hold medical insurance? (Informational for emergency services only) Yes___ No___

Name of Insurance Company: ____