



The Bever

WELLNESS CENTER

A Colonial Company

Westover

Berkeley Square

Colonial At Home

Colonial Schools

Colonial Foundation

The Coach House
Tavern & Grille

Coach House
Catering

Membership Packet 2012

513-867-4007

855 STAHLHEBER ROAD

HAMILTON, OHIO 45013

WWW.COLONIALSENIORS.ORG

THE BEVER WELLNESS CENTER AT WESTOVER

Hours of Operation	
Monday - Thursday	7:00 a.m. – 6:00 p.m.
Friday	7:00 a.m. – 5:00 p.m.
Saturday	8:00 a.m. – 12:30 p.m.
Sunday	Closed

Staff Contact Information		
Cara Winship	Director of Wellness	867-4009
Becky Allen	Wellness Manager	887-5797
Michelle Buker	Wellness Coordinator	867-4007
Jocelyn McCauley	Wellness Specialist	867-4007
Nancy Fetters	Wellness Specialist	867-4018
Lori Cook	Wellness Specialist	785-2026
Emily Cook	Wellness Assistant	820-5047

General Information

- Each participant of the Center will be provided with the opportunity to participate in a Wellness Orientation prior to use of the facility. This Orientation will help you to become familiar with the exercise equipment, aquatics area, and procedures of the Center. You will also have the opportunity during this appointment to have a personalized exercise program designed for you by a trained Fitness Instructor. Please call 820-5047 to schedule your Wellness Orientation.
- The Center offers fully equipped men's and women's locker rooms including free locker and towel service. Locker locks are available at the Fitness Desk for use by participants while they are in the Center. Please return locks to the Fitness Desk before leaving the Center.
- Please sign in using your member card at the Fitness Desk prior to using the Exercise Room or attending classes.
- The Fitness and Aquatics Instructors are available to assist you with any of your exercise or fitness related questions or concerns.

- As a courtesy to other participants, please wipe off all exercise equipment after use, return weights to rack, and return cardiovascular equipment controls to beginning levels when you are finished.
- Appropriate footwear in all areas of the facility is recommended. A closed-toed, supportive, soft-soled shoe is the best choice for your safety and protection.
- Appropriate attire is also recommended. Please refrain from wearing clothing that may restrict movement associated with exercise or loose clothing that could potentially get caught in the exercise machines.
- Should you discover a piece of equipment in need of repair, please bring this to the attention of a staff member.
- For your safety, please observe all posted signs throughout the Center.
- Up to date information can be found on the bulletin board across from the locker room doors.
- Should you have any questions or concerns about exercise equipment, procedures of the Center, safety guidelines, or physical sensations experienced while participating at the Center, please consult a staff member promptly. We are here to assist you and will do all that we can to make your time in the Center as safe and enjoyable as possible!
- Please refrain from smoking in any area of the Bever Wellness Center.

Health/Medical History Questionnaire, Informed Consent and Physician Consent Form

- Please complete the Health/Medical History Questionnaire, Informed Consent and Physician Consent Form prior to beginning your exercise program at the Center. Staff of the Center will gladly assist in the process of completing and obtaining these forms when necessary.
- Physician Consent may be waived if there are no conditions present that hinder involvement in activities of the Center.
- Please notify the Center staff of any change in conditions or restrictions (diabetes, arthritis, orthopedic injury, high blood pressure, heart disease, etc.) that could create risk or harm to you or other participants or staff with exercise. Please obtain the required paperwork to be updated.
- Please notify a Center staff member of any changes to or additions of medication while participating at the Center.
- The Center staff will gladly work with a participant's physician or therapist to coordinate a prudent program for a given situation.

Aquatics Area

- Please observe all posted signs and placards in the pool area.
- To prevent injury, please do not dive or jump into the pool.
- Towels are provided for all participants of the Center. Please return soiled towels into the proper receptacles in the locker rooms before exiting the Center.
- For sanitary reason, please shower before entering and upon leaving the pool and hot tub.
- Use caution when wearing jewelry into the pool as lost jewelry may not be able to be recovered.
- For your personal safety, please limit time spent in the whirlpool to 10-15 minutes. Long exposure may result in nausea, dizziness or fainting.
- The Chair Lift is available for participants who may need assistance entering and exiting the pool. The lift is designed to be self-operable by the occupant, but staff is available to assist when necessary.

Rejuvenation Room

- The Rejuvenation Room is a space dedicated to relaxing both the body and mind. The room will be used for numerous activities and services including, but not limited to, massage, aromatherapy, meditation, and relaxation.
- Participants are invited to enjoy the Rejuvenation Room during scheduled times (for a massage appointment, for example), and are also encouraged to utilize and enjoy the space at times other than for a scheduled activity.
- If you would like to reserve the room for a specific time or activity, please contact the Fitness Desk to schedule a time block.

Guest Procedures

- Guests are welcome at the Bever Wellness Center. Please have your guest follow the sign in procedures of the Center. Also notify a staff member of your guest's attendance within the Center so that we may offer a proper welcome and orientation to your guest. Guest fee is \$5 per visit.

Parking

- Free and convenient parking is available in the Bever Wellness Center Parking Lot located just after the Ruder Apartments entrance on Brookwood Avenue. The parking lot provides direct entrance into the Westover Retirement Community. Because the door leads into a hallway with resident apartments, the entrance door will be locked at all times. You will need to enter the password WELL or 9355 into the keypad located at the door in order to gain access. A doorbell has also been placed at the entrance in case the password is ever forgotten. Upon entering the building, go straight and follow the hallway to the atrium where the coffee machine is located.

HEALTH/MEDICAL HISTORY QUESTIONNAIRE

Last Name *First Name* *Middle Initial*

Address *City* *State* *Zip*

Home Phone *Email Address* *Birth Date*

Sex: Male Female Age: _____

Emergency Contact Name *Phone Number* *Relationship*

Physician's Name *Phone Number* *Fax Number*

Address *City* *State* *Zip*

A. Renewing Members Only: Have any previous conditions changed or have any new conditions developed within the last year? Yes or No

If yes, please indicate below. If no, you may stop here.

B. Medical History: Do you have or have you had any of these conditions?

General	Yes	Describe condition (include date of occurrence)
Heart Disease		
High/Low Blood Pressure		
Stroke		

Diabetes		
Chest Pain/angina		
Irregular/rapid heart beats		
Respiratory disorders		
Anemia		
Peripheral vascular disease		
Recent illness		

C. Musculoskeletal Conditions:

General	Yes	Describe condition (include date of occurrence)
Arthritis		
Osteoporosis		
Painful joints		
Swelling in joints		
Muscular weakness		
Muscle pain		
Former injuries/fractures		
Joint replacement		
Other:		

D. Neurological Conditions:

General	Yes	Describe condition (include date of occurrence)
Light headedness/dizziness		
Balance problems		

Please list any and all illnesses, hospitalizations, or surgical procedures within the past two years.

Please list all medical conditions that are currently being supervised by a physician.

Has a physician restricted activities due to a medical condition or surgical procedure?
If yes, please describe.

Do you currently have a condition that would affect your ability to do strenuous exercise?
If yes, please describe.

Do you currently use an assistive device to walk (walker, cane, wheelchair, etc)?
If yes, please describe.

List Any Allergies/Allergic reactions to the following:

I. Medication - Prescribed or over-the-counter:

Are you taking any of the following medications:

Type of Medication	Yes	For what condition?	For How Long?
Anti-depressants			
Tranquilizers			
Sleeping pills			
Anticoagulants			
Blood pressure			
Cholesterol/fat lowering			
Med. for arrhythmia			
Insulin			
Oral diabetic medication			
Estrogen			
Thyroid hormones			
Anti-inflammatory			
Ulcer medication			
Allergy medication			
Antihistamines			
Diuretics			
Pain medication			
Daily Vitamin			
Supplement			
Other			

Member Signature

Date

Staff Signature

REQUEST TO PARTICIPATE IN VOLUNTARY EXERCISE PROGRAM AND INFORMED CONSENT, INDEMNIFICATION, AND RELEASE AGREEMENT

I request permission to engage in a voluntary exercise program in order to attempt to improve my physical fitness and wellness. I understand that the purpose of the exercise program includes, but is not limited to, developing and maintaining cardiovascular endurance, muscular strength and endurance, flexibility and agility.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform the instructor of those symptoms.

I also understand that muscle soreness is a normal and expected part of any exercise regimen-whether initially working towards physical fitness or increasing intensity on an already established program. The difference between muscle soreness and musculoskeletal injury is judgmental, but I will agree to refrain from further participation until I have had any concerns resolved by appropriate medical personnel.

I have truthfully answered the Health/Medical History Questionnaire to the best of my knowledge regarding my past and current health. In the event that a medical clearance must be obtained prior to my participation in the exercise program due to discretion of the instructor, I agree to consult my physician and obtain written permission from my physician before commencement of any exercise program.

I understand that although The Bever Wellness Center at Westover's facilities, equipment, services, and programs are designed to provide a safe level of beneficial exercise and enjoyment, there is an inherent risk that use or misuse of such facilities, equipment, services, and programs may result in injury to me. In consideration of being allowed to participate in this voluntary exercise program, I agree to assume all risk of such exercise. In further consideration, I agree that I, my heirs, executors, administrators, personal representatives, guardians, successors, and assigns will indemnify and hold harmless Colonial, its directors, operators, and employees (hereby referred to as releasees), from all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, whether caused by the negligence of the releasees or otherwise, during, or arising in any way from my voluntary participation in activities at The Bever Wellness Center.

I have read and voluntarily signed this Request to Participate in Voluntary Exercise Program and Informed Consent, Indemnification, and Release Agreement. I further agree that no oral representations, statements, or inducements apart from this written agreement have been made.

Print Name

Date

Signature

Signature of Spouse

PAYMENT INFORMATION

1) Please make checks payable to: The Bever Wellness Center

2) If paying by Credit Card: Amex MasterCard Visa (please circle)

Name as it appears on card _____

Card # _____ Expiration Date _____

3 Digit Security Code (last 3 digits on the back of card) _____

I authorize The Bever Wellness Center to charge my credit card \$ _____ per month until 12/31/2012.

Signature: _____

I/We understand the terms and conditions of this membership and I/We agree to pay the above amount indicated. I/We hereby purchase a membership from The Bever Wellness Center for the time period specified on this Agreement. I/We acknowledge that this membership may not be transferred nor cancelled and that payment is due upon enrollment.

Signature: _____

Date: _____

Signature: _____

PHYSICIAN'S CONSENT FORM

I, _____ (please sign your name), hereby agree to allow the undersigned physician's office to release the following information to The Bever Wellness Center (fax number: 513-895-0102) for the purpose of verifying my ability to participate in physical activity at the Center.

Physician's Name: _____

Physical Health Status

Please list absolute values and rate health status indicators as L-Low, N-Normal, or H-High.

_____ Height			
_____ Body Weight	L	N	H
_____ Blood Pressure	L	N	H
_____ Resting Heart Rate	L	N	H
_____ Blood Glucose	L	N	H
_____ Total Cholesterol	L	N	H
_____ HDL _____ LDL			

Physician's Statement:

The above named individual may participate, without restriction, in all physical activities offered at the Bever Wellness Center at Westover.

The above named individual may participate, with restriction, in limited physical activities offered at the Bever Wellness Center. *(A trained Fitness Instructor will design a program for the individual based on stated restrictions.)*

Restrictions: _____

The above named individual may not participate in physical activities and programs offered at the Bever Wellness Center at Westover.

Justification: _____

Physician's Signature: _____

Phone Number: _____ Fax Number: _____

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(Date / Initial) For Office Use Only

_____/_____/_____ I have read or been informed of the Physician's Consent Form as stated above. I agree to adhere to any restrictions or limitations noted.

_____/_____/_____ I have completed the Health/Medical History Questionnaire and waive the recommendation to provide a completed Physician's Consent Form.