

**SENIOR CENTER MEMBERSHIP FORM**  
**Department of Parks, Recreation and Community Services**

Mo / Day / Year  
(Office use only)

- ASHBURN SENIOR CENTER       CARVER SENIOR CENTER  
 CASCADES SENIOR CENTER       DULLES SOUTH SENIOR CENTER  
 LEESBURG SENIOR CENTER

*The minimum age requirement for Senior Programs is 55 years of age. Information provided on this form is used for statistical purposes by the Area Agency on Aging (AAA) and the Virginia Department for the Aging. Membership forms are kept in a secure environment and not shared with any other organization or individual without your consent and serve as a health form for senior day trips.*

**PLEASE PRINT AND COMPLETE BOTH SIDES OF APPLICATION:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Preferred First Name \_\_\_\_\_  
Month Day Year

Are you a Loudoun County resident?  Yes  No

***(Membership fee is \$36 for resident, \$54 for non-residents, checks payable to County of Loudoun)***

Mailing Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email\* Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(cell) \_\_\_\_\_ other: \_\_\_\_\_

**Emergency Contact Information:**

1st Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

1st Contact Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

2nd Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

2nd Contact Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

**PLEASE CHECK APPROPRIATE RESPONSE:**

Annual household income: For family of one: \$14,580 or below or \$14,581 or above  
For family of two: \$19,720 or below or \$19,721 or above

Family in Home: Yourself Spouse Dependent others \_\_\_\_\_

Gender: Male or Female

Marital Status: Married Widowed Separated Divorced Single

Race: Other: \_\_\_\_\_

Ethnicity:

***- please complete medical information on back side and sign-***

**Medical information is requested for your protection when participating in Loudoun County Senior Programs (including meal program). As with all information, we maintain strict rules of confidentiality designed to protect your privacy. This form also serves as your health form for senior day trips.**

**PLEASE PRINT:**

Last Name \_\_\_\_\_ Preferred First Name \_\_\_\_\_

Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Physician's Phone: (\_\_\_\_\_) \_\_\_\_\_

Overall Health: \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

All Allergies: \_\_\_\_\_

All Medical Conditions or Diagnoses: \_\_\_\_\_

All Current Medications (include over the counter)	Dose and Frequency (mg./x per day)	Reason Prescribed

Communication: \_\_\_\_\_ English \_\_\_\_\_ other (specify) \_\_\_\_\_

\_\_\_\_\_ cannot communicate \_\_\_\_\_ hearing impaired \_\_\_\_\_ sign/gestures

**Member Agreement:**

*I recognize, understand and accept that all activities and transportation provided by the Department of Parks, Recreation and Community Services (PRCS) involve some risk. I understand that Loudoun County PRCS will not be responsible for me when I am traveling to and from an activity via transportation not provided by the County of Loudoun. I give permission for Loudoun County PRCS to use photographs and videos of me for publicity in order to increase community awareness of PRCS programs in publications and other media without limitation. I acknowledge that qualified staff and volunteers who have signed a Loudoun County Confidentiality Agreement will handle such media and this document. Further, by signing below, I agree to comply with all center guidelines and any special health guidelines put in place that require my cooperation to reduce the risk of spreading communicable disease.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

ADA – Loudoun County Department of Parks, Recreation and Community Services is committed to complying with the Americans with Disabilities Act (ADA). If you need reasonable accommodations in order to participate, call the appropriate Community Center/Program Area at least one week prior to the start of the activity.

**Office Use Only:** Rectrac h/h # \_\_\_\_\_ Membership Card # \_\_\_\_\_ Date: \_\_\_\_\_  
PeerPlace \_\_\_\_\_ Staff Initial \_\_\_\_\_