



Northern Illinois Special Recreation Association

## Northern Illinois Special Recreation Association Fitness Program Waiver

TO: Medical practitioner  
FROM: Northern Illinois Special Recreation Association (NISRA)  
RE: Recommendation for participation  
DATE:

*NOTE: Participants that have a current Special Olympics APP form on file need not complete this Waiver.*

Your patient (name below) desires to register to participate in a NISRA fitness program. These programs involve physical exercise through the use of aerobics, treadmill, weights, and/or resistance equipment. A typical fitness program meets 1-2 times/week for up to 1 hour. NISRA provides a close-staff-to-participant ratio and the exercises are chosen based upon the participant's ability level.

In order for your patient to participate in this type of program, we are requesting a medical clearance. Please complete the following information and return it to the NISRA office by the date indicated below.

---

---

**Part 1: For completion by NISRA Participant.**

Print Name: \_\_\_\_\_

I give permission for (medical practitioner name) \_\_\_\_\_ to complete this medical clearance form. It needs to be sent to NISRA prior to the start of the programs which begins on \_\_\_\_\_ in order for me to be allowed to participate.

Date: \_\_\_\_\_ Participant signature: \_\_\_\_\_

---

---

**Part 2: For completion by medical practitioner licensed to administer physical examinations in the State of Illinois.**

Please check:

I support my patient's participation in this program with no restrictions

I support my patient's participation in this program with the following restrictions: \_\_\_\_\_

I do not recommend my patient's participation in the program for the following reasons: \_\_\_\_\_

Date: \_\_\_\_\_ Medical Practitioner's signature: \_\_\_\_\_

Medical practitioner's address: \_\_\_\_\_

---

---

**Please return to:** NISRA  
285 Memorial Drive  
Crystal Lake, IL 60014  
  
(815) 459-0388 Fax\*

\*A facsimile signature shall substitute for and have the same effect as an original signature.

**This form will be valid for 2 years from the date of the Medical practitioner's signature.** The form will need to be re-submitted if the participant has medical treatment that could affect his/her participation.