

Physician Waiver *(only to be completed if medical conditions exist)*

I, _____ Physician Name _____, MD-DO, give my permission for
 _____ Participant Name _____ to participate in fitness programs, exercise or
 dance classes sponsored by Senior Circle Association. The Participant is solely responsible for determining
 his/her level of endurance and capabilities. It is the responsibility of the Participant to notify program sponsor of
 changes in physical condition.

I have listed any known medical condition(s) for which the program sponsor should be aware and any
 corresponding limitations.

Medical Conditions	Limitations
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ Physician Signature	_____ Print/Type Physician's Name	_____ Date
_____ Participant Signature	_____ Print Participant's Name	_____ Date
_____ Received By		_____ Date

Form required upon membership and then at least annually thereafter.