WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year .

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

❑ **Cleared without restriction** ❑ **Cleared, with recommendations for further evaluation or treatment for:** _____

_____

❑ **Not cleared for** ❑ **All sports** ❑ **Certain sports:** _____ **Reason:** _____

Recommendations: _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)*: _____ **OR APNP:** _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

* Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

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WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

Student's Name _____

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____

Policy Numbers and Address _____

Emergency Information

Allergies _____

Other Information (medication,etc.) _____

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** _____
(e.g., tetanus/diphtheria;measles, mumps, rubella;hepatitis A, B;influenza;poliomyelitis;pneumococcal;meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.
2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to:Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____