WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ATHLETIC PERMIT CARD - PHYSICAL

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) ____________ (MI) ____ 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 ________

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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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 □ 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 there-under (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 ____________

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

SCHOOL YEAR 20____ - 20____

Physical Date ____________

NAME ____________ (Last, First, Middle Initial) GRADE ________ DATE OF BIRTH ____________

Present Address ____________ Telephone ____________

Parent's Place of Employment ____________

Family Physician ____________ Family Dentist ____________

Name of Private Insurance Carrier ____________

Policy Numbers and Address ____________

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports.
2. I also attest to the fact that the above named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there-under (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.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.

PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing card.

SIGNATURE OF PARENT ____________ DATE ____________

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

PLEASE TURN THIS FORM OVER

INSURANCE COVERAGE FOR ATHLETICS

(This form must be completed and turned in to the office **before** the participant may begin practice for any sport.)

Dear Parents:

The School District is aware that many families have adequate health and accident insurance, however, there are some families whose coverage is not adequate or who have no insurance. Those students participating in interscholastic sports are particularly susceptible to accidents and injuries and, although the school is not legally responsible for such injuries except in cases of negligence, we do feel an obligation to see that all athletes have proper insurance protection. A low cost group insurance plan is being offered through the school. If you are interested in this insurance plan please contact the District Sports Administrator or the School Principal.

OUR FAMILY HEALTH INSURANCE POLICY IS ADEQUATE IN CASE OF AN EMERGENCY, AND WE THEREFORE DECLINE TO ENROLL OUR SON OR DAUGHTER IN AN ADDITIONAL INSURANCE PROGRAM. BELOW IS THE INFORMATION PERTAINING TO OUR INSURANCE COVERAGE:

Name of Student ______________________________ Grade ____________

Address ______________________________ Phone ____________

Parent's Place of Employment ______________________________

Family Physician ______________________________

Name of Private Insurance Carrier and Address ______________________________

Policy Number ______________________________ Expiration Date ____________

I hereby give my permission for the student named above to practice and compete, representing Oregon Senior High School, in W.I.A.A. approved interscholastic sports. I also grant permission for emergency medical care to be given by the team physician or any other physician present if my son/daughter is injured during practice or interscholastic competition.

I understand that by signing this form, payment for medical treatment of an injury resulting from practice or athletic competition will be assured by the above identified policy and not by school purchased athletic insurance coverage.

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❖ **Parent/Guardian Signature** **Date**

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PLEASE TURN THIS FORM OVER