WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION-ATHLETIC PERMIT CARD

(Print or Type)

1. Examination taken after April 1 is good for the following **TWO SCHOOL YEARS.**
2. Examination taken before April 1 is good for the remainder of that **SCHOOL YEAR** and the following **SCHOOL YEAR.**

NAME (Last) ____________ (First) ____________ (Middle Initial) ____________

Grade ____________ Age ____________ Sex ____________

School ____________ City ____________ State ______ Zip Code ____________

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

Sports or school activities in which this student cannot participate are (if none – write NONE) ____________

____

SIGNATURE OF LICENSED PHYSICIAN*: ____________ **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 Physican Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION-ATHLETIC PERMIT CARD

NAME (Last) ____________ (First) ____________ (Middle Initial) ______ DATE OF BIRTH ____________

Present Address ____________ Telephone ____________

Parents' 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 interscholastic sports except those restricted on this card.
2. I further grant permission for any medical records pertaining to the health of the above named student be made available as necessary to the proper school district personnel and appropriate health care providers, including emergency medical personnel.
3. It is recommended that information regarding your child's allergies and prescribed medication be made available.

SIGNATURE OF PARENT/GUARDIAN ____________ **DATE** ____________