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_____ GRAD. YEAR _____ DATE OF BIRTH_____
Last First Middle Initial

Grade_____ Age_____ Sex _____ Student #_____ School_____

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_____ Zip_____

Phone_____

DATE OF EXAMINATION

***** 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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Current Address_____ Zip_____ Phone_____

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 sports.
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.

_____ DATE_____

(Signature of Parent)

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

(see over for District Waiver card)