WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION - ATHLETIC PERMIT CARD (side 1)

(PRINT OR TYPE)

1. Examination taken after April 1 is good for the following TWO SCHOOL YEARS (will need alternate year card the second year).
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 Physician 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 (side 2)

NAME (Last) ________________ (First) __________ (Middle Initial) ___ 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 to the above named student to practice and compete and represent the school in WIA 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 __________