

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.

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; polio/myelitis; 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 _____

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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.

❖ Parent/Guardian Signature

Date

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