WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD **CLASS OF: _____**

____BADGER ____WEST ____EAST **(ex: 2022)**

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
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) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex _____ Grade _____ Present Address _____ Telephone _____

□ **Cleared without restriction** □ **Cleared, with the following qualifications:** _____

_____

□ **Not cleared** □ **Pending further evaluation** □ **For all sports** □ **For certain sports:** _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*: _____

Clinic Name _____Telephone _____ Date of Examination _____

Address/Clinic _____ City _____ State _____ Zip Code _____

***** Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information **Allergies** _____

Other Information (medication, etc.) _____

Immunizations □ **Up to date (see attached documentation)** □ **Not up to date - specify** _____ (e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I, as a parent or legal guardian of the above athlete, have read, understand, and therefore agree to support the policies and rules set forth for athletes at West Bend High and Middle Schools and give my son/daughter permission to participate under those conditions in West Bend School District Club and WIAA approved sports.
2. I hereby give my permission for the above-named student to practice and compete and represent the school in West Bend School District Club and WIAA approved interscholastic sports except those restricted on this card.
3. As the parent (or legal guardian) of the above-named athlete, I agree to be financially responsible for the safe return of all athletic equipment issued to him/her. I further agree to hold my son/daughter financially accountable for any and all equipment, which he/she might lose, misplace, or damage.
4. I realize that there is an inherent risk of injury through participating in all sports. I realize this risk may be severe, including the risk of fractures, brain injuries, paralysis or even death. I have sufficient insurance and am willing to take full financial responsibility for any and all injuries sustained by my child while participating in the interscholastic athletic program under the direction of West Bend High and Middle Schools.
5. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (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 _____

OFFICE USE: ___Scan ___Skyward ___Family ID ___File