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

School Year 20___ - 20___

Wisconsin Interscholastic Athletic Association

Physical Examination Card & 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** & the following **SCHOOL YEAR**

Name _____ Date of Birth _____/_____/_____
Last First Middle Initial

Present Address_____ Phone_____

Grade_____ Age _____ Sex: ☐ M ☐ F Sports_____

School _____ City _____

The above named student has been examined & there are no apparent contradictions to participating in interscholastic athletic activities except as follows: Sports or school activities in which this student cannot participate are (if non – write NONE)

_____

_____

SIGNATURE OF LICENSED PHYSICIAN OR SURGEON _____

Physician's Address _____

Physician's City/State _____

Physician's Telephone (_____)_____ **Date of Examination** _____/_____/_____

Parent's 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 except those restricted on this card.
2. I further grant permission for any medical records pertaining to the health of the above named student to be made available necessary to the proper school district personnel and appropriate care providers, including emergency medical personnel.

_____ _____/_____/_____
Signature of Parent **DATE**

ELMBROOK SCHOOLS – MEDICAL CONSENT FORM

Athlete _____ Sport_____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

In the event that any emergency arises during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the athletic trainer to provide the needed emergency treatment to the athlete prior to his admission to the medical facilities. I further grant permission for the Emergency Medical facility to release any necessary medical information pertaining to my son's/daughter's injury/illness to the attending athletic trainer.

_____ _____/_____/_____
Signature of Parent **Date**

Allergies _____

Routine Medications _____

Family Physician _____ Phone _____

Phone #'s where parents can be reached: 1st contact name/number _____

2nd contact name/number_____ 3rd contact name/number_____