## ■ PREPARTICIPATION PHYSICAL EVALUATION

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

## **CLEARANCE FORM**

## WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

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 followyear and the following school year.	ving two school years; physical examination	n taken before April 1 is valid o	nly for the remainder of that school
NAME (Last)	(First)	(Middle Initial)	Date of Birth
Age Sex Grade School		City	
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 preparticipa in the sport(s) as outlined above. A copy of the physical exam is on record lete has been cleared for participation, a physician may rescind the cleared ents/guardians).	l in my office and can be made available to the	e school at the request of the pa	rents. If conditions arise after the ath-
Name of Physician (Print/Type)			
SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*:			
Clinic Name			
Address/Clinic	City	Stat	e Zip Code
Telephone	Date of E	xamination	
* Physicians may authorize Nurse Practitioners to stamp the	nis card with the physician's signature or the r	name of the clinic with which th	e 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) (e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; int			
I hereby give my permission for the above named stud- cept those restricted on this card.	ent to practice and compete and repres	sent the school in WIAA ap	proved interscholastic sports ex-
<ol> <li>Pursuant to the requirements of the Health Insurance Por as "HIPAA"), I authorize health care providers of the stude may be attending an interscholastic event or practice, to appropriate school district personnel such as but not limit tant to the Athletic Director and/or other professional heal</li> </ol>	ent named above, including emergency m disclose/exchange essential medical inf red to: Principal, Athletic Director, Athletic	nedical personnel and other sometical personnel and other sometical personnel and other sometical personnel personne	similarly trained professionals that y and treatment of this student to eam Coach, Administrative Assis-

DATE \_\_\_\_