Sun Prairie High Schools Athletic Participation & Physical Form

Student Name _____ Grade _____

Address _____ City _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Parents/Guardians Name(s) _____

PERMISSIONS:
I hereby give my permission for the above-named student to practice, compete, travel with, and represent Sun Prairie Schools in WIAA-approved interscholastic sports excepting those restricted on this form by a licensed physician, (MD or DO) / APNP*. I also grant permission to publish pictures of the student and release their name for external publication on the Sun Prairie Area School District website, which is accessible to the Internet and local media. (Policy IIBGB)

UNIFORMS/EQUIPMENT:
I understand that I take full responsibility for the safe return of all athletic uniforms and equipment issued to the above named student and agree to reimburse the school for the replacement value of lost/stolen/damaged uniforms and/or equipment. I understand that any failure to reimburse may affect the student's athletic eligibility.

EMERGENCY MEDICAL CARE: All health concerns/protocols/medications need to be provided to the coach/ath. trainer by parents.
I grant permission for the above student, in case of accident or injury during athletic participation, to be given emergency attention/care by the athletic trainer, team physician, or any other physician present and to be conveyed to an emergency medical facility if needed. I understand that all costs associated with such treatment will be the responsibility of the parents/guardians, and that Sun Prairie School District will assume no liability for the costs. I also grant permission for any medical records pertaining to the health of the above student are made available as necessary to the proper district personnel.

INFORMED CONSENT:
I understand and accept that there are certain physical risks incumbent upon participation in athletics. I realize the Sun Prairie Area School District is not responsible for, and does not provide insurance of any kind for student-athletes. Knowing this, I hereby give the above named student permission to participate in athletics for this school year. We can provide you with voluntary insurance coverage information available at your expense.

SIGN HERE

EXTRA-CURRICULAR RULES AND REGULATIONS AGREEMENT
By signing this form, we are attesting to the fact that we have read, understand, and will abide by the Sun Prairie School District Extra-Curricular Rules and Regulations Handbook, (available on the high schools Athletics websites), as well as all rules set forth by the WIAA, and that full permission is granted to the above student to participate in Sun Prairie High School athletics. We realize the rules and regulations are in effect year round, on and off the playing court/field.

** _____ _____ ** _____ _____

Parent/Guardian Signature **Date** **Student-Athlete Signature** **Date**

ALTERNATE YEAR

☐ Check this box if this is an alternate physical year. Parents/Student can check this box if:

- Student has a current physical card on file in the Athletic Department office.

NOTE: *Physicals dated AFTER April 1st are good for the following TWO SCHOOL YEARS. Physicals dated BEFORE April 1st are good for the remainder of that SCHOOL YEAR and the following SCHOOL YEAR.*

PHYSICIAN

PHYSICAL CARD

WIAA ATHLETIC PERMIT CARD – [Physician's Use Only]
All students participating in Interscholastic Athletics must have this card on file at their school prior to practice or participation.
The above-named student has been examined and may participate in interscholastic athletic activities except as follows (if none, write "none" or explain restrictions):_____

_____

Allergies/Other Medication Information:_____

Hospital/Clinic Affiliation: _____Phone _____

Address/City/State: _____

Signature of Licensed Physician (MD or DO)/APNP _____

Date of Exam: _____

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

PHYSICIAN: PLEASE ADD CLINIC STAMP

Please remember to sign and date.