

**WISCONSIN INTERSCHOLASTIC ASSOCIATION - PHYSICAL EXAMINATION CARD**

(Print or Type)

Waunakee Community School District's School Board

policy states that all incoming 7th, 9th & 11th graders must have a physical dated after April 1st of the current year.

NAME \_\_\_\_\_  
Last First Middle Initial  
Grade \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
School \_\_\_\_\_ City \_\_\_\_\_

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

Sports or school activities in which this student cannot participate are (if none - write NONE) \_\_\_\_\_

SIGNATURE OF LICENSED PHYSICIAN\* \_\_\_\_\_

Address \_\_\_\_\_

City and state \_\_\_\_\_

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.

Revised 9/98

**WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION - ATHLETIC PERMIT CARD**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
Last First Middle Initial

Present Address \_\_\_\_\_ Telephone \_\_\_\_\_

Parents' 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 interscholastic 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 be made available as necessary to the proper school district personnel and appropriate health care providers, including emergency medical personnel.
3. It is recommended that information regarding your child's allergies and prescribed medication be made available.

\_\_\_\_\_  
(Signature of Parent) DATE \_\_\_\_\_