



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.

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.

SIGN HERE

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

ALTERNATE YEAR	<input type="checkbox"/> Check this box if this is an alternate physical year. Parents/Student can check this box if: <ul style="list-style-type: none"> Student has a current physical card on file in the Athletic Department office. <p>NOTE: Physicals dated <i>AFTER</i> April 1st are good for the following TWO SCHOOL YEARS. Physicals dated <i>BEFORE</i> April 1st are good for the remainder of that SCHOOL YEAR and the following SCHOOL YEAR.</p>
-----------------------	---

PHYSICIAN

PHYSICAL CARD	<p>WIAA ATHLETIC PERMIT CARD – [Physician's Use Only] All students participating in Interscholastic Athletics must have this card on file at their school <u>prior to practice or participation</u>. The above-named student has been examined and may participate in interscholastic athletic activities except as follows (if none, write "none" or explain restrictions): _____</p> <p>Allergies/Other Medication Information: _____</p> <p>Hospital/Clinic Affiliation: _____ Phone _____</p> <p>Address/City/State: _____</p> <p>Signature of Licensed Physician (MD or DO)/APNP _____</p> <p>Date of Exam: _____</p>	<p>PHYSICIAN: PLEASE ADD CLINIC STAMP</p> <p>← Please remember to sign and date.</p>
----------------------	--	---

*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.

Adapted Sports League

Sun Prairie Area School District

Student Name _____ Date of Birth _____ Gender M/F
Address _____ Home Phone _____
School _____ Grade _____

I certify that the above student has been medically evaluated for participation in the Adapted Sports League with recommendations documented below. (Student with Down syndrome, evaluation results for Atlantoaxial instability : _____)

Indoor Soccer-Fall

- Cleared to Participate, no restrictions
- Not Cleared
- Cleared with the following restrictions: _____

Floor Hockey-Winter

- Cleared to Participate, no restrictions
- Not Cleared
- Cleared with the following restrictions: _____

Wiffle Ball-Spring

- Cleared to Participate, no restrictions
- Not Cleared
- Cleared with the following restrictions: _____

Physicians Name (Printed/Typed) _____ Date _____

Address _____ Phone _____

Physician Signature _____