

**WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ALTERNATE PHYSICAL EXAMINATION INFORMATION**

*ALL students participating in interscholastic athletics **MUST** have either their physical exam information **OR** their alternate year information on file at their school **PRIOR TO PRACTICE OR PARTICIPATION.***

**PLEASE PRINT NEATLY**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Present Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent’s Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Family Dentist \_\_\_\_\_

Name of Private Insurance Carrier (required) \_\_\_\_\_

Subscriber Member Name \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Information**

List any allergies, medications, or other conditions: \_\_\_\_\_

Immunizations:  Up-to-Date  Not Up-to-Date-specify: \_\_\_\_\_

(e.g.: tetanus/diphtheria, measles, mumps, rubella, hepatitis A/B, influenza, poliomyelitis, pneumococcal, meningococcal, varicella)

1. I give my permission for the above-named student to practice, compete, and represent the school in WIAA-approved interscholastic sports.
2. I also attest to the fact that the above-named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. It is recommended that information regarding your child’s allergies and prescribed medications be made available.
4. I further grant permission for any medical records pertaining to the health of the above-named student to be made available as necessary to the proper school district personnel and appropriate health care providers, including emergency personnel.

**It is the student’s responsibility to read and follow all WIAA rules of eligibility.**

***These rules are posted on the School District of South Milwaukee website.***

<http://www.sdsm.k12.wi.us/schools/high/activities-athletics.cfm>

Having been cautioned and warned, we sign this document voluntarily, intelligently, and with full knowledge of its legal consequences. Furthermore, we release the School District of South Milwaukee, the members of the School District of South Milwaukee School Board, and their respective employees and agents, and Midwest Orthopedic Specialty Hospital affiliated with Wheaton Franciscan Healthcare Sports Medicine Institute Representatives from any liability and or claims of negligence that may occur during participation in any practice and/or event which is anyway related to the co-curricular activity. We further understand that the School District of South Milwaukee does not provide health insurance on behalf of participants in such co-curricular activities and that the responsibility for medical coverage for any injury or illness sustained as a result of participation does not lie with the District. We understand that this release will apply to me, and personal representatives, heirs, and assigns.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Student Athlete Signature \_\_\_\_\_

Date \_\_\_\_\_