WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

SCHOOL YEAR 20_____-20_____

PHYSICAL DATE:_____

NAME:_____ GRADE_____ DATE OF BIRTH:_____
LAST FIRST MIDDLE INITIAL

PRESENT ADDRESS:_____ PHONE:_____

PARENT'S PLACE OF EMPLOYMENT:_____

FAMILY PHYSICIAN:_____ FAMILY DENTIST:_____

NAME OF PRIVATE INSURANCE CARRIER (PRIMARY INSURED):_____

1. I hereby give my permission for the above named student to practice and complete and represent the school in WIAA 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 ths school year.
3. Pursuant to the requirement of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"). I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professions that may be attending an interscholastic event or practice , to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or professional health care providers, for purposes of treatment, emergency care and injury record-keeping.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.

PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing this card.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE:_____