

WIAA - ATHLETIC PERMIT 26-27

Signed by Physician - Please Print or Type

Name _____ Grade _____ Grad Year _____

School: Marquette High School, Milwaukee, WI 53208

The above named student has been examined and there are no restrictions to participating in interscholastic activities except as follows: (list sports or activities in which the student cannot participate - if none – write none:

SIGNATURE OF LICENSED PHYSICIAN: _____ OR

APNP: _____

Address: _____ City _____ State _____ Zip _____

Telephone _____ **Date of Examination** _____

Examination Facts: Height _____ Weight _____ Pulse _____ Blood Pressure _____

List any abnormal findings re: skin, eye, ears, nose, throat, teeth, neck, lungs, heart, chest, liver, spleen, and spine:

Joint Function: List any abnormalities re: the neck, shoulders, elbows, wrists, hands, hips, knees, ankles, and feet:

Other: List any neurological abnormalities re: hernia, genitalia, HGB or hematocrit, or urinalysis:

WIAA RULE – STUDENT PARTICIPATING IN TRY-OUTS OR ATHLETICS DURING THE ABOVE SCHOOL YEAR MUST HAVE ON FILE IN THE ATHLETIC OFFICE,

Physical examination taken April 1, 2025 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

STUDENT MEDICAL HISTORY 26-27

Name _____ Grade Level _____ FR SO JR SR Grad Year _____
Please Print Circle

This medical history form must be completed annually by the parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition, which would make it hazardous to participate in an athletic event. **All students must have this form on file at their school prior to practice or participation in any sport.**

Please use the lines below to explain any questions answered - yes.

- | | | | | | |
|---|---|--|--|---|---|
| 1. During the past 12 months: | | 7. Is he missing any paired organ (eye, kidney, etc.)? | Y | N | |
| 2. a. Was he hospitalized? | Y | N | | | |
| b. Did he have any injuries requiring medical attention? | Y | N | 8. Is he wearing any removable dental appliance? | Y | N |
| c. Did he have any illness lasting more than one week? | Y | N | 9. Is he allergic to any medication? (aspirin, Tylenol)? | Y | N |
| 2. Does he take medication regularly? | Y | N | | | |
| 3. Is there any reason to limit his participation in any sport? | Y | N | | | |
| 4. Has he had a concussion or been knocked unconscious? | Y | N | | | |
| 5. Has he ever had a convulsion? | Y | N | | | |
| 6. Is he now under a doctor's care? | Y | N | | | |

Parent Signature _____ Date _____