

2026 - 27 Loyal Middle - High School Athletic Code



WIAA INTERSCHOLASTIC ATHLETIC ASSOCIATION EMERGENCY CONTACT & CONSENT FORM

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE INITIAL

Street Address: _____

City: _____ Zip Code: _____ Home #: _____

Father's Name: _____ Cell #: _____ Work #: _____

Mother's Name: _____ Cell #: _____ Work #: _____

Medication(s) your son/daughter is presently taking if any? _____

Any allergies or special medical information or restriction? _____

PLEASE CONTACT THE FOLLOWING INDIVIDUAL IF A PARENT/GUARDIAN CANNOT BE REACHED:

Name: _____ Phone: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

IF EMERGENCY MEDICAL TREATMENT IS REQUIRED, WHAT FACILITY DO YOU PREFER YOUR CHILD BE TAKEN TO FOR TREATMENT:

☐ Marshfield Clinic Health System

☐ Other: _____

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 my 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. I authorize school personnel to transport my son/daughter to a physician's office and/or emergency room for treatment in the event that emergency medical care is needed while he/she is involved in extra-curricular activities. Further, I authorize the physician and hospital staff to treat my son/daughter as they deem necessary in the emergency situation. The parent/guardian whose signature appears below guarantee payment of expenses incurred.
4. I understand that there are inherent risks involved in participating in any athletic activity including the risk of serious injury or even death.

PARENT/GUARDIAN SIGNATURE

DATE