Wisconsin Interscholastic Athletic Alternate Year Athletic Permit Card

School Year 20_____-20_____

Physical Date_____

Name_____ Grade_____ Date of Birth_____
Last First M.I.

Present Address_____

Telephone_____

Parent's Place of Employment_____

Family Physician_____ Family Dentist_____

Name of Private Insurance Carrier_____
Telephone_____

Subscriber Member Name (Primary Insured) _____

1. I hereby give my permission for the above named student to practice, compete, and represent the school in WIAA approved sports.
2. I also attest to the face 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. Pursuant to the requirements 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 professional 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 other 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 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 card.

Signature of Parent_____ Date_____

ALL STUDENTS PARTICAPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS ALTERNATE YEAR CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTIVE OR PARTICPATION