WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD SCHOOL YEAR 20_______ - 20______

Physical Date			OOL TLAIT 20 20	J		
NAME				GRADE	DATE OF BIRTH	
	Last	First	Middle Initial			
Present Addres	ss				Telephone	
Family Physicia	an		Fa	mily Dentist		
Name of Private	e Insurance Carrier				Telephone	
I hereby gi I also attes Pursuant to ize health or practice Principal, A of treatment	ive my permission for st to the fact that the a o the requirements of care providers of the the disclose/exchang Athletic Director, Athle the mergency care at	f the Health Insurance Portability and student named above, including em- ge essential medical information reg- stitc Trainer, Team Physician, Team C and injury record-keeping	ury or illness serious enough to d Accountability Act of 1996 an ergency medical personnel and arding the injury and treatmen oach, Administrative Assistant	o warrant a med d the regulations I other similarly t t of this student to the Athletic Di	AA approved sports. ical evaluation prior to participating this school year. is promulgated thereunder (collectively known as "HIPAA"), I author- rained professionals that may be attending an interscholastic event to appropriate school district personnel such as but not limited to: rector and/or other professional health care providers, for purposes	
4. It is recom PARENT: If the	mended that informat nere is any question th	tion regarding your child's allergies a hat this student may not be qualified	nd prescribed medication be m for athletic competition without	nade available. t, at least, a part	ial re-evaluation, contact your medical advisor before signing card.	
SIGNATURE OF P	PARENT				DATE	
ALL STUDE	NTS PARTICIPATING I	N INTERSCHOLASTIC ATHLETICS MI	JST HAVE THIS ALTERNATE YE	AR CARD ON FIL	E AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION	
	WISCO	ONSIN INTERSCHOLASTIC AT	HLETIC ASSOCIATION A	LTERNATE Y	EAR ATHLETIC PERMIT CARD	
Physical Date		SCH	100L YEAR 20 20)		
NAME				GRADE	DATE OF BIRTH	
	Last	First	Middle Initial			
Present Addres	ss				Telephone	
Parents' Place	of Employment					
Family Physicia	an		Fa	mily Dentist		
Name of Private	e Insurance Carrier				Telephone	
or practice Principal, A of treatmed 4. It is recom PARENT: If the	care providers of the e, to disclose/exchang Athletic Director, Athle nt, emergency care al imended that informat here is any question the	student named above, including emige essential medical information registic Trainer, Team Physician, Team C nd injury record-keeping	ergency medical personnel and arding the injury and treatmen oach, Administrative Assistant and prescribed medication be mader that the formal for athletic competition without	to other similarly to tof this student to the Athletic Di nade available. t, at least, a part	AA approved sports. ical evaluation prior to participating this school year. is promulgated thereunder (collectively known as "HIPAA"), I author- rained professionals that may be attending an interscholastic event to appropriate school district personnel such as but not limited to: rector and/or other professional health care providers, for purposes ial re-evaluation, contact your medical advisor before signing card. DATE	
					E AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION	
\$			&		·	
		ONSIN INTERSCHOLASTIC AT		ILTERNATE Y	EAR ATHLETIC PERMIT CARD	
NAME		First		GRADE	DATE OF BIRTH	
					Telephone	
					Telephone	
I hereby g I also atter Pursuant to reactive Principal, of treatme It is recome.	I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports. 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. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I author ize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic ever 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 purpose of treatment, emergency care and injury record-keeping. It is recommended that information regarding your child's allergies and prescribed medication be made available. ARENT: 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.					
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SIGNATURE UF F	ANEINI				DATE	