Greenfield Middle School

3200 West Barnard Avenue, Greenfield, Wisconsin 53221 ■ Phone: 414-282-4700 ■ FAX: 414-282-1017

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION.

TO BE FILLED OUT BY PARENT/GUARDIAN: (Please print or type)

STUDENT NAME (last): _____ (first) _____ (Middle Initial) _____

Parent's Place of Employment: _____

Family Physician: _____ Family Dentist: _____

Name of Private Insurance Carrier: _____ Telephone: _____

Subscriber Member Name (Primary Insured): _____

EMERGENCY INFORMATION:

Allergies: _____

Other Information (medications, etc.): _____

Immunizations: (Please check one) _____ up to date _____ not up to date – specify _____
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; varicella, etc)

1. I hereby give my permission for the above named student to practice, compete, and represent the school in WIAA approved interscholastic sports except those restricted on this card.

2. Pursuant to the requirements of the Health Insurance Portability and Countability 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 professionals 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.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

TO BE FILLED OUT BY PHYSICIAN: (Please print or type)

Physical examination taken April 1 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 NAME (last): _____ (first) _____ (Middle Initial) ____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City _____

Student's Present Address _____ Telephone _____

____ Cleared without restrictions _____ Cleared with the following qualifications: _____

____ Not cleared for: _____ All sports _____ Certain sports (specify) _____

Reason _____

Recommendations: _____

SIGNATURE OF LICENSED PHYSICIAN (MD or DO*): _____ or APNP: _____

Address: _____ City: _____ State _____ Zip _____

Telephone: _____ Date of Examination: _____

* Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.