TO BE USED ON FIRST SPORT OF THE YEAR FRESHMAN AND JUNIOR YEAR

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION - ATHLETIC PERMIT CARD

1. Examination taken after April 1 is good for the following TWO SCHOOL YEARS.
2. Examination taken before April 1 is good for the remainder of the SCHOOL YEAR and the following SCHOOL YEAR.

LAST NAME _____ **FIRST** _____ **INITIAL** _____

School Hamilton High School **Address** W220 N6151 Town Line Road Sussex, WI 53089 **Phone** (262) 246-6471

School Year _____ **Grade 9** ❑ **10** ❑ **11** ❑ **12** ❑ **Age** _____ **Male** ❑ **Female** ❑

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows: Sports or school activities in which this student cannot participate are (if none - write NONE)

Signature of Licensed Physician*: _____ **OR APNP:**

Address _____ **City** _____ **State** WI **Zip** _____

Telephone _____ **Date of Examination** _____

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

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

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION
Physical Card for School Year - _____ - _____

Name (Last) _____ First _____ Initial _____

Date of Birth _____ Age _____ Home Phone _____

Home Address _____ City _____ State WI Zip _____

Father Employer _____ Phone _____

Mother Employer _____ Phone _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

Name of Private Insurance Carrier _____

Address _____ Policy # _____

1. I hereby give permission for the above named student to practice, compete and represent Hamilton High School in WIAA approved Interscholastic Sports except those restricted on this card.
2. I further grant 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. It is recommended that information regarding your child's allergies and prescribed medication be made available.

Parent/Guardian Signature _____ **Date** _____