WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ADTERNATE YEAR ATHLETIC PERMIT CARD SCHOOL YEAR 20 - 20

Physical Date		- 1LAN 2020		
NAMELast			GRADE	DATE OF BIRTH
		Middle Initial		
				Telephone
				Telephone
I also attest to the fact that Pursuant to the requiremen ize health care providers of or practice, to disclose/exc Principal, Athletic Director, of treatment, emergency ca It is recommended that info PARENT: If there is any questi	In for the above named student to practice at the above named student has had no injury its of the Health Insurance Portability and Act the student named above, including emerginange essential medical information regard Athletic Trainer, Team Physician, Team Coact and injury record-keeping. In the student may not be qualified for in that this student may not be qualified for insurance and injury record-keeping.	or illness serious enough to countability Act of 1996 and ency medical personnel and ng the injury and treatment h, Administrative Assistant to prescribed medication be athletic competition without,	warrant a medi I the regulations other similarly t of this student o the Athletic Di ade available. at least, a parti	cal evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I author- rained professionals that may be attending an interscholastic even to appropriate school district personnel such as but not limited to rector and/or other professional health care providers, for purposes al re-evaluation, contact your medical advisor before signing card.
SIGNATURE OF PARENT				DATE
ALL STUDENTS PARTICIPATI	NG IN INTERSCHOLASTIC ATHLETICS MUST	HAVE THIS ALTERNATE YEA	AR CARD ON FIL	E AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
	SCONSIN INTERSCHOLASTIC ATHL			EAR ATHLETIC PERMIT CARD
			CDADE	DATE OF BIDTH
NAMELast	First	Middle Initial	GRADE	DATE OF BIRTH
Present Address				Telephone
Family Physician		Far	mily Dentist	
Name of Private Insurance Car	rrier			Telephone
or practice, to disclose/excl Principal, Athletic Director, of treatment, emergency ca	the student named above, including emerging hange essential medical information regard Athletic Trainer, Team Physician, Team Coacure and injury record-keeping.	ency medical personnel and ng the injury and treatment h, Administrative Assistant to	of this student of the Athletic Di	A approved sports. cal evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I authorrained professionals that may be attending an interscholastic evento appropriate school district personnel such as but not limited to rector and/or other professional health care providers, for purposes al re-evaluation, contact your medical advisor before signing card.
				DATE
				E AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
- &		- &		-
WI Physical Date	SCONSIN INTERSCHOLASTIC ATHI	ETIC ASSOCIATION A L YEAR 20 20	FRNATE Y	EAR ATHLETIC PERMIT CARD
NAME	First		GRADE	DATE OF BIRTH
		Middle Initial		
Present Address				Telephone
, ,				
Name of Private Insurance Ca	rrier			Telephone
I hereby give my permissio I also attest to the fact that Pursuant to the requiremer ize health care providers of or practice, to disclose/exc Principal, Athletic Director, of treatment, emergency ca	nts of the Health Insurance Portability and Af the student named above, including emerg hange essential medical information regard Athletic Trainer, Team Physician, Team Coac are and injury record-keeping. prmation recarding vour child's allergies and	or illness serious enough to countability Act of 1996 and ency medical personnel and ing the injury and treatment th, Administrative Assistant to prescribed medication be m	o warrant a medid the regulations other similarly to of this student to the Athletic Diade available.	AA approved sports. ical evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I author rained professionals that may be attending an interscholastic ever to appropriate school district personnel such as but not limited to rector and/or other professional health care providers, for purpose ial re-evaluation, contact your medical advisor before signing card.
, ,	· · · · · · · · · · · · · · · · · · ·	·		
				DATE