**WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD**

**St. Croix Central School District, Hammond, Wisconsin**

School Year 20___ - 20___

STUDENT NAME (Last) ____________________ (First) ____________________ (Middle Initial) ________

DATE OF BIRTH ____________________ SEX ____________________ GRADE ____________________

ADDRESS ____________________ City ____________ State ____________ Zip Code ____________

PARENT/GUARDIAN NAME (Print/Type) ____________________

ADDRESS ____________________ TELEPHONE ____________________

PARENTS/GUARDIAN PLACE OF EMPLOYMENT ____________________

FAMILY PHYSICIAN ____________________ FAMILY DENTIST ____________________

NAME OF PRIVATE INSURANCE CARRIER ____________________ POLICY NUMBER ____________________

Where parent/guardian can be reached if not at home:

TELEPHONE 1 ____________________ TELEPHONE 2 ____________________ TELEPHONE 3 ____________________

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

NAME ____________________ TELEPHONE ____________________

NAME ____________________ TELEPHONE ____________________

1. I hearby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports.
2. 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.
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 professionals that may be attending an interscholastic event or practice, to disclose/exchange 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 made 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.

**STUDENT SIGNATURE** ____________________ DATE ____________________

**PARENT/GUARDIAN SIGNATURE** ____________________ DATE ____________________

*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.