KENOSHA UNIFIED SCHOOL DISTRICT

PARENT-ATHLETE ACTIVITIES CODE AND WIAA RULES OF ELIGIBILITY

SIGN-OFF FORM

This form must be completed and submitted to the Athletic Director prior to a student being declared eligible for practice and competition.

WE, THE PARENTS OF ___________________________, HAVE READ,

Please Print

UNDERSTAND, AND HAVE DISCUSSED THE ACTIVITIES CODE OF CONDUCT AND THE WIAA RULES OF ELIBIBILITY WITH OUR SON/DAUGHTER. WE FURTHER AGREE TO PERMIT OUR SON/DAUGHTER TO PARTICIPATE IN ACCORDANCE WITH THE CONDITIONS SET FORTH IN THE ACTIVITIES CODE OF CONDUCT. WE FUTHER CERTIFY THAT IF WE DID NOT UNDERSTAND ANY OF THE INFORMATION IN BOTH DOCUMENTS, WE HAVE SOUGHT AND RECEIVED AN EXPLANATION OF THE INFORMATION PRIOR TO SIGNING THIS STATEMENT.

____ ______________

Student's Signature (Required) Grade

____ ______________

Parent's Signature (Only one Parent’s signature required) Date

<u>COACHES/ADVISORS MUST RETAIN A SIGNED COPY OF THIS FORM IN THEIR FILES FOR EACH STUDENT INVOLVED IN THEIR ACTIVITY</u>

One agreement must be signed each year for all student participation in Categories 1, 2, and 3 activities. Please list the activities your son/daughter will be involved in during the present school year.

Sports	Activities

KENOSHA UNIFIED SCHOOL DISTRICT

Athletic Permission Form

Student Name: ____ Grade Level: _________

Address: _____________________________________ Zip Code: _____ Birth Date: ___________

Telephone: (   ) ______________ Cell Phone: (   ) ________________

School ___________________________

Health Insurance Carrier: ___________________________ Policy Number: ____________________

Permission to Participate

I hereby give my permission for the above-named student to practice, compete, and represent the school in WIAA regulated interscholastic sports except any restrictions as noted on the current, effective physical examination card as completed by a licensed physician or advanced practice nurse prescriber. This letter shall be provided to each student when they sign up to participate in a sport. No athlete will be permitted to participate until this form is signed and on file with building athletic director. Plus, this form serves as a notification of parental (guardian) permission to participate in the sport of:

____.

Responsibility to Return All School-Issued Uniforms/Equipment

I agree to be financially responsible for the safe return of all athletic uniforms and equipment issued to him/her. I understand that my son/daughter is responsible for any uniform or equipment that is assigned specifically to him/her, and agree to reimburse the school the actual replacement value of the uniforms/equipment in the event that they are lost or stolen. I understand that failure to reimburse KUSD in a timely fashion could affect my son/daughter's athletic ability.

Permission for Emergency Medical Care and Conveyance

I further grant permission for my son/daughter, named above, in case of injury as a result of athletic participation, to be given emergency attention/care by the coaching staff, athletic trainer, the team physician or any other physician present, and to be conveyed to an emergency medical facility, if needed. I understand that all medical costs that could occur from such conveyance and subsequent treatment are the sole responsibility of the parents/guardians, and I understand that KUSD will assume no liability for the cost of said conveyance or treatment.

Informed Consent

I understand that injuries could occur as a result of participation in athletics. I understand that these injuries could include minor injuries such as bruises or abrasions, muscle strains, sprains, or broken limbs. I understand that is possible that a catastrophic injury could occur rendering my son/daughter paralyzed, and that death could also occur as a result of a catastrophic injury.

Insurance Waiver

I certify that I have adequate insurance coverage on student named above to cover medical expenses in the event of an athletic-related accident or injury.

Signature

By signing this form, I am attesting to the fact that I understand and agree to all conditions set forth on this form and that if I have not understood any information, I have sought and received an explanation, and I am fully aware that I am granting permission for the above-named student to participate in the KUSD Athletic Program.

______________________________	__________	______________________________	__________
Parent/Guardian Signature	Date	Student-Athlete Signature	Date

(1) This restriction applies to normal nonschool games as well as "gimmicks," such as reduced numbers competition (3-on-3 basketball, 6 player soccer, e.g.), specific skill contests (punt, pass, and kick, shooting contests, free throws, 3 point, e.g.), fun runs, etc.

(2) A student who was a member of a school team during the previous year may not delay reporting for the school team beyond the school's official opening day of practice in order to continue nonschool training and/or competition.

B. During the school year before and/or after the school season of a sport, a student-athlete may participate in sport activities outside of school with these restrictions:

(1) A student-athlete must not participate in nonschool programs, activities, camps, clinics and/or competition that is limited to individuals who are likely to be candidates for the school team in that sport in the following season.

(2) Nonschool activities in which students are engaged may not resemble in any way a school team practicing or competing out-of-season.

(3) Nonschool team rosters may not include more than the following number of participants from the same school: Volleyball, Hockey, Basketball - 3; Soccer - 6; Baseball, Softball - 5; and Football - 4

C. In the summer nonschool roster restrictions are not in effect and members of a schools team may voluntarily assemble with their teammates (without school and/or school coach involvement) at their own discretion.

D. A student-athlete or his/her parents must pay the fee for specialized training or instruction such as camps, clinics, and similar programs.

E. A student-athlete may not be instructed except during the school season of a sport and approved summer contact days by the person who will be his/her coach in that sport in the following school season. The sports of baseball, cross country, golf, gymnastics, softball, swimming, tennis, track & field, and wrestling are exempt from this rule, BUT only (a) during the summer months and (b) if the program involved is not limited to individuals who are likely to be candidates for the school team in that sport in the following season.

F. A student-athlete must not participate in an all-star game or similar contest except for summertime activities (a) within the same league or program (e.g., softball game between divisions of same league) or (b) in which a team is selected to represent a league in post-season play (e.g., Babe Ruth league team). Some post-season all-star opportunities may be permitted for 12th graders who have completed high school eligibility in a particular sport. Check with your Athletic Director to be certain.

Detach and Return to Athletic Director

PARENT-ATHLETE RULES OF ELIGIBILITY SIGN-OFF FORM

I certify that I have read, understand, and agree to abide by all of the information contained in this bulletin. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

____
School Name

____________________________________ ____________________
Parent/Guardian's Signature Date

____________________________________ ____________________
Student-Athlete's Signature Date

This form must be completed and submitted to the Athletic Director prior to a student being declared eligible to practice and compete.

KUSD Athletics Waiver and Release of Claims

By signing below, I, the undersigned, expressly agree and understand that my child:________________________________is participating in Kenosha Unified School District (KUSD) extracurricular activities at his/her own risk. I understand the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization (WHO). Further, I acknowledge that COVID-19 cases have been confirmed in Kenosha County, Wisconsin and surrounding counties. In accordance with guidance issued by the WHO, the United States Centers for Disease Control and Prevention (CDC), and the Wisconsin Department of Health Services (WDHS), for slowing the transmission of COVID-19, I hereby agree, represent, and warrant that my child shall not enter District property and engage in the foregoing activities within 14 days after (i) returning from highly impacted areas subject to a CDC Level 3 Travel Health Notice, (ii) exposure to any person returning from areas subject to a CDC Level 3 Travel Health Notice, or (iii) exposure to any person who has a suspected or confirmed case of COVID-19. I agree that I am aware of the CDC Travel Health Notices list (https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html) and agree to check this list prior to signing this waiver. I hereby agree, represent, and warrant my child will not enter District property and participate in the foregoing activities if he/she (i) experiences symptoms of COVID-19, including, without limitation, fever, cough, or shortness of breath, or (ii) has a suspect or diagnosed/confirmed case of COVID-19.

Kenosha Unified School District has taken reasonable steps to implement recommended guidance and protocols issued by Public Health Agencies for slowing the transmission of COVID-19, including, without limitation, the restrictions set forth above. I understand the inherent dangers for exposure to COVID-19 and other injuries while engaged in the foregoing activities on District property, which could result in quarantine requirements, serious illness, disability, and/or death and hereby assumes full responsibility for, and risk of, illness, bodily injury, or death. Having read and understood the above warning, I recognize the importance of reviewing and following the guidance issued by the WHO, CDC, and WDHS, as well as the District's policies and procedures related to same. By signing this agreement, I agree to be responsible for my child's personal safety and hygiene while engaged in the foregoing activities on District property and abide by District rules and procedures related to social distancing

and use of personal protective equipment (PPE), including, but not limited to face masks or shields.

Having read the above warning and having understood the dangers and potential risks involved with participating in the foregoing activities, I give my consent as the parent/legal guardian of my child, to participate in the foregoing recreational activities. I further agree to hold the Kenosha Unified School District, its employees and agents and any and all persons or entities holding thereunder, including any and all policies of insurance, harmless from any and all claims, suits, obligations or other liabilities which arise or may arise out of my child's engagement in the aforementioned activities on District property. Further, I agree to indemnify any of the aforementioned persons and/or entities to the extent of any damage claims, including attorney fees, which arise or may arise out of my child's activities on District's property.

I hereby certify that I have read the above provisions and agree to abide by the terms of this Agreement.

____________________________________ ____________________________________

Parent/Guardian Signature Date Student Signature Date

____________________________________ ____________________________________

Parent/Guardian Name (Printed) Student Name (Printed)

Kenosha Unified School District

In accordance with Wisconsin’s Sidelined For safety Act 172, we the undersigned acknowledge having received education about the signs, symptoms, and risks of sport related concussion. We understand that students are prohibited from any participation until this form is completed and returned to the school’s Athletic Office.

I acknowledge my responsibility to report to my coaches, parent(s)/guardian(s) any signs or symptoms of a concussion and agree to abide by all KUSD concussion protocols.

____

printed name of student/athlete *signature* *date*

I, the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion and agree to abide by all KUSD concussion protocols.

____

printed name of parent/guardian *signature* *date*

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ______ Age ______ Grade ______ School ______________ Sport(s) ______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ______________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________ Signature of parent/guardian ______________ Date ______

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HE0503 9-2681/0410

■ Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____

Name ____ Date of birth ____________________

Sex ________ Age __________ Grade _____________ School ____________________________ Sport(s) ______________________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________________ Signature of parent/guardian ______________________________ Date ____________

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■ Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name ____________________ Date of birth ____________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________

____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ____________

Reason ____________

Recommendations ____________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ____________ Date ________

Address ____________ Phone ________

Signature of physician ____________, MD or DO

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Preparticipation Physical Evaluation
CLEARANCE FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

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

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.

NAME (Last) ______________________ (First) ____________________ (Middle Initial) _______ Date of Birth _______________

Age ______ Sex ______ Grade ______ School ______________________________ City ____________________________

Present Address ____ Telephone ____________________

❑ **Cleared without restriction** ❑ **Cleared, with the following qualifications:** ____________________________________

____

❑ **Not cleared** ❑ **Pending further evaluation** ❑ **For all sports** ❑ **For certain sports:** ______________________________

Reason: ____

Recommendations: ____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) ____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/APNP*: ____

Clinic Name ____

Address/Clinic ______________________________ City ____________________ State _______ Zip Code __________

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.

Parents' Place of Employment ____

Family Physician ______________________________ Family Dentist ______________________________

Name of Private Insurance Carrier ____ Telephone ________________

Subscriber Member Name (Primary Insured) ____

Emergency Information

Allergies ____

Other Information (medication, etc.) ____

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** ____________________________
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and 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 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 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 ____________________

Emergency/Health Form – Kenosha Unified School District

YR: ID #: BUS #:

Student Last Name	First Name	Middle Name	Birthdate	School	Grade	Parents Email	Cell Phone

Student Address (check if new) ☐	City	State	Zip	Home Phone (check if unlisted) ☐ ( )	Family's Doctor Name	Doctor's Phone ( )	Child's Dentist Name	Dentist's Phone ( )

Parent/Guardian Name	Address	City	Home Phone ( )	Child Lives With ☐ Yes ☐ No	Employed By	Work Phone ( )	Shift Hours
Parent/Guardian Name	Address	City	Home Phone ( )	Child Lives With ☐ Yes ☐ No	Employed By	Work Phone ( )	Shift Hours

Please list additional emergency contacts below in the order you wish them to be called:

Name	Address	Home Phone ( )	Work Phone ( )	Relationship to Student
Name	Address	Home Phone ( )	Work Phone ( )	Relationship to Student

Confidential Health Information If your child's doctor has told you your child has any of the problems noted below, please "X" all that apply and answer the questions related to the problem

☐ My child has no known health problems ☐ **MY CHILD'S HEALTH CONDITION IS POTENTIALLY LIFE THREATENING**

Attention Deficit Disorder with or without hyperactivity ☐ Does your child have a form of Autism? If yes, describe ____

Allergies, Type: ☐ Foods, list foods: ____

☐ Bees/Wasps/Other Insects ☐ Latex/Rubber ☐ Allergies to Medications: (list here) ____

☐ Other, please describe ____

☐ **Asthma** or other breathing problems, describe: ____

☐ **Cancer,** type: ____ Currently in: ☐ Treatment ☐ Remission

☐ **Birth Defects,** list/explain: ____

☐ **Blood Disorder** other than HIV/AIDS (i.e. Sickle Cell), describe: ____ ☐ Elevated Lead Level

☐ **Diabetes** (check): ☐ **Type I** or ☐ **Type II** List types of insulin, dose and times taken on back

☐ **Emotional/Psychological problems,** describe: ____

☐ **Heart Condition,** describe: ____

☐ **Organ Transplant,** list organ: ____

☐ **Seizure Disorder,** describe type: ____ Date of last seizure: ____

☐ **Swallowing, Stomach or Intestinal disorders:** ____

☐ **Vision, Hearing or Speech problems,** describe: ____ ☐ Hearing Aids ☐ Ear Tubes ☐ Glasses

☐ **Other,** describe: ____

**** LIST ALL MEDICATIONS AND/OR TREATMENTS ON THE BACK OF THIS FORM****

If my child becomes ill at school and you cannot reach me by phone, the principal or his/her designee has permission to contact any of the emergency contacts listed above. You have our permission to contact the Student's Physician for consultation if needed. If a serious illness or accident occurs at school, I understand that my child will be sent by rescue squad to the emergency room. (All expenses charged by the hospital are responsibility of the Parent/Guardian.)

Signature of Parent/Legal Guardian: ____ **Date:** ____ **Language Used:** ____

Student Name: ____

MEDICATION (List names of all medications child takes, doses and times given):
Each medication given at school requires written parental consent. Each prescription medication requires a physician's written order and written parental consent. Medication forms may be obtained from the school office.

MEDICATION (name)	**DOSE**	**TIME or SITUATION (when given)**	**WHO ADMINISTERS (child/adult)**	**WHERE KEPT (home/school/backpack…)**

1 ____

2 ____

3 ____

4 ____

5 ____

6 ____

7 ____

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

School Year 20_____-20_____

Physical Date ____________________

Name _______________________________________ Grade________ Date of Birth ________________

Last First Middle Initial

Present Address ____ Telephone __________________

Parents' Place of Employment ____

Family Physician ____________________________ Family Dentist ________________________________

Name of Private Insurance Carrier ______________________________ Telephone __________________

Subscriber Member Name (Primary Insured) ____

1. I hereby 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 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.
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 the card.

Signature of Parent ____ Date ______________________

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