

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

Student's Name _____
 Parents' Place of Employment _____
 Family Physician _____ Family Dentist _____
 Name of Private Insurance Carrier _____
 Policy Numbers and Address _____

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)

- 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.
- 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 _____

Preparticipation Physical Evaluation

(Medical History to be Retained by Physician/Provider)

PHYSICAL EXAMINATION FORM

Name (Last) _____ (First) _____ (Middle Initial) _____ Date of birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ / _____ / _____
 Vision R 20 / _____ L 20 / _____ Corrected: Y N PUPILS: EQUAL _____ UNEQUAL _____

Follow-Up Questions on More Sensitive Issues

- Do you feel stressed out or under a lot of pressure? Yes No
- Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? Yes No
- Do you feel safe? Yes No
- Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? Yes No
- During the past 30 days, did you use chewing tobacco, snuff, or dip? Yes No
- During the past 30 days, have you had at least 1 drink of alcohol? Yes No
- Have you ever taken steroid pills or shots without a doctor's prescription? Yes No
- Have you ever taken any supplements to help you gain or lose weight or improve your performance? Yes No
- Questions from the Youth Risk Behavior Survey (<http://cdc.gov/healthyYouth/yrs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. Yes No

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Feet/toes			

*Multiple-examiner set-up only.
 +Having a third party present is recommended for the genitourinary examination

Name of physician or APNP (print/type) _____ MD/DO or APNP: _____
 Address _____ Telephone _____
 Signature of physician: _____ Date: _____