WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD SCHOOL YEAR 20_______ - 20______

Physical Date			OOL TLAN 20 20)		
NAME				GRADE	DATE OF BIRTH	
	Last	First	Middle Initial			
Present Addres	ss				Telephone	
Family Physicia	an		Fa	mily Dentist		
Name of Private	e Insurance Carrier				Telephone	
I hereby gi I also attes Pursuant to ize health or practice Principal, A of treatment It is recome.	ive my permission for st to the fact that the a o the requirements of care providers of the a, to disclose/exchang Athletic Director, Athle nt, emergency care au imended that informat	the Health Insurance Portability and student named above, including eme e essential medical information rega tic Trainer, Team Physician, Team Co do Injury record-keeping. In regarding your child's allergies at	ury or illness serious enough to Accountability Act of 1996 an regency medical personnel and triding the injury and treatmen pach, Administrative Assistant and prescribed medication be medication be medication.	o warrant a medi d the regulations I other similarly t t of this student to the Athletic Di nade available.	cal evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I author- rained professionals that may be attending an interscholastic event 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 P	PARENT				DATE	
ALL STUDE	NTS PARTICIPATING I	N INTERSCHOLASTIC ATHLETICS ML	IST HAVE THIS ALTERNATE YE	AR CARD ON FIL	E AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION	
	WISCO	NSIN INTERSCHOLASTIC AT	-	LTERNATE YI		
				CDADE	DATE OF BIRTH	
NAME	Last	First	Middle Initial	GRADE	DATE OF BIRTH	
Present Addres	ss				Telephone	
					Telephone	
I hereby gi I also attes Pursuant tize health or practice Principal, of treatmet It is recomparent: If the SIGNATURE OF P	ive my permission for st to the fact that the a on the requirements of care providers of the et al. to disclose/exchang athletic Director, Athle nt, emergency care as imended that informathere is any question the PARENT	student named above, including eme e essential medical information rega- tic Trainer, Team Physician, Team Cr di njury record-keeping. ion regarding your child's allergies au nat this student may not be qualified	rgency medical personnel and trding the injury and treatmen each, Administrative Assistant and prescribed medication be made for athletic competition without	other similarly to the tof this student to the Athletic Dinade available. The total to the available and the available available. The total to	AA approved sports. cal evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I author- rained professionals that may be attending an interscholastic event 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. DATE E AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION	
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	WISCO	ONSIN INTERSCHOLASTIC AT SCH	HLETIC ASSOCIATION A	LTERNATE Y	EAR ATHLETIC PERMIT CARD	
	Last	First	Middle Initial	VIII/DL	DATE OF BIRTH	
Present Addres	SS				Telephone	
Parents' Place	of Employment					
Family Physicia	an		Fa	mily Dentist		
Name of Privat	e Insurance Carrier				Telephone	
Subscriber Mer 1. I hereby g 2. I also atte: 3. Pursuant t ize health or practice Principal, of treatme 4. It is recom	I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports. 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. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I author ize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic ever 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 purpose of treatment, emergency care and injury record-keeping.					
	, ,	That this student may not be qualified	•	, , ,	, ,	
CIGINALONE OF F	AUTERI				DATE	