WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

Physical Date		5	CHUUL YEAR 2U	20	
NAME				GRADE	DATE OF BIRTH
Las		First			
Present Address					Telephone
Name of Private Insu	rance Carrier				Telephone
I hereby give my I also attest to th Pursuant to the r ize health care p or practice, to di Principal, Athletic of treatment, em It is recommende	permission for the above nated that the above nated in the Heist requirements of the Heist roviders of the student sclose/exchange essers. Director, Athletic Train ergency care and injury and that information required.	ove named student to practical amed student has had no alth Insurance Portability a named above, including ential medical information reper, Team Physician, Team y record-keeping.	and Accountability Act of 1996 mergency medical personnel a egarding the injury and treatm Coach, Administrative Assista s and prescribed medication be	at the school in WIA a to warrant a medic and the regulations and other similarly tr ent of this student t at to the Athletic Dir	A approved sports. al evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I authorained professionals that may be attending an interscholastic event o appropriate school district personnel such as but not limited to: eactor and/or other professional health care providers, for purposes al re-evaluation, contact your medical advisor before signing card.
SIGNATURE OF PAREN	Т			1	DATE
					EAT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
~			· &		
Physical Date		C	ATHLETIC ASSOCIATION CHOOL YEAR 20		AR ATHLETIC PERMIT CARD
NAME		First		GRADE	DATE OF BIRTH
			Middle Initial		
Present Address					Telephone
Parents' Place of Em	ployment				
Family Physician				Family Dentist	
Name of Private Insu	rance Carrier				Telephone
I hereby give my I also attest to th Pursuant to the r ize health care p or practice, to di Principal, Athletic of treatment. em	permission for the above national fact that the fact t	amed student has had no alth Insurance Portability a named above, including e ntial medical information re- ner, Team Physician, Team y record-keeping.	and Accountability Act of 1996 mergency medical personnel a egarding the injury and treatm Coach, Administrative Assista	n to warrant a medic and the regulations and other similarly tr ent of this student t nt to the Athletic Dir	A approved sports. Al evaluation prior to participating this school year. al evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I authoratined professionals that may be attending an interscholastic event of appropriate school district personnel such as but not limited to: ector and/or other professional health care providers, for purposes all re-evaluation, contact your medical advisor before signing card.
SIGNATURE OF PAREN	Γ			[DATE
ALL STUDENTS PA	ARTICIPATING IN INTER	RSCHOLASTIC ATHLETICS	MUST HAVE THIS ALTERNATE	YEAR CARD ON FILI	AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
\$			· &		
Dhara's al Data			ATHLETIC ASSOCIATION		AR ATHLETIC PERMIT CARD
Physical Date					
NAME	et	Firet	Middle Initial	GRADE	DATE OF BIRTH
					Telephone
				-	
					Telephone
I hereby give my I also attest to the size health care progradice, to different principal, Athletiof treatment, em It is recommend.	ne fact that the above n requirements of the He providers of the student isclose/exchange esser c Director, Athletic Trair rergency care and injury ed that information reas	ove named student to practive named student has had no latth Insurance Portability a named above, including ential medical information river, Team Physician, Team y record-keeping.	and Accountability Act of 1996 emergency medical personnel a egarding the injury and treatm ocach, Administrative Assistates and prescribed medication by	h to warrant a medicand the regulations and other similarly to ent of this student int to the Athletic Direct made available.	A approved sports. al evaluation prior to participating this school year. promulgated thereunder (collectively known as "HIPAA"), I authorained professionals that may be attending an interscholastic evento appropriate school district personnel such as but not limited to ector and/or other professional health care providers, for purposes al re-evaluation, contact your medical advisor before signing card.
SIGNATURE OF PAREN	Т	•		-	DATE