WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION PHYSICAL EXAMINATION CARD
St. Croix Central School District, Hammond, Wisconsin

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.

STUDENT NAME (Last) _____ (First) _____ (Middle Initial)_____

DATE OF BIRTH _____ SEX _____ GRADE _____

ADDRESS _____ City_____ State _____ Zip Code_____

PHYSICIAN'S REPORT

Name of Physician (Print/Type) _____

Clinic Name _____

Clinic Address _____ City_____ State _____Zip Code _____

Telephone _____ Date of Examination _____

☐ Not cleared ☐ Pending further evaluation ☐ For all sports ☐ For certain sports _____

Reason _____

Recommendations_____

I have examined the above-named student and completed the pre-participation 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).

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

PARENT STATEMENT/EMERGENCY INFORMATION

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.