WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION/PHYSICAL EXAM INFORMATION **SPORT** ________________________________

Examination taken after April 1 is good for following ***TWO SCHOOL YEARS.*** *An Alternate Year form will be required the second year.*

1. *Examination taken before April 1 is good for the remainder of that* ***SCHOOL YEAR*** *and the following* ***SCHOOL YEAR****.*
2. *ALL students participating in interscholastic athletics* ***MUST*** *have either their physical exam information on file at their school* ***PRIOR TO PRACTICE OR PARTICIPATION.***

PLEASE PRINT NEATLY

Last Name ____ First Name __________________________ Middle Initial __________

School ____ Grade ______ Age________ ☐ Male ☐ Female

Present Home Address ____ Telephone___________________________

PHYSICIAN MUST COMPLETE ALL INFORMATION IN BOX

☐ 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 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).

PRINT (or type) NAME OF PHYSICIAN ____ CLINIC NAME ____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP* ____ DATE OF EXAM ______________

Clinic Address ____City______________________________State_______________Zip_______

Telephone #___________________________________ Fax #________________________________

**Physicians may authorize Nurse Practitioners/Physician Assistants to stamp this card with the physician's signature or name of clinic with which the physician is affiliated.*

Parent's Name ____Work Phone ____________________________ Cell Phone ____________________________

Place of Employment ____Work Telephone ____

Family Physician ____ Family Dentist____

Name of Private Insurance Carrier ___________________________________ Subscriber Member Name ________________________________ Phone ____________________

Emergency Information

List any allergies, medications, or other conditions ____

____

Immunizations ☐ Up to Date ☐ Not Up to Date – specify: ____

(e.g.: tetanus/diphtheria; measles, mumps, rubella; hepatitis A/B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Legal Waiver and Release

1. I give my permission for the above named student to practice, compete and represent the school in WIAA and/or approved interscholastic sports except those restricted on this card.
2. I grant permission for any medical records pertaining to the health of the above named student be made available as necessary to the proper school district personnel and appropriate health care providers, including emergency medical personnel.
3. It is recommended that information regarding your child's allergies and prescribed medications be made available.
4. We authorize consent between the athletes, parents, School District of South Milwaukee representative, Midwest Orthopedic Specialty Hospital affiliated with Wheaton Franciscan Healthcare representative or any healthcare provider to discuss any pertinent information in regards to current or previous medical conditions perform necessary evaluative procedures and secure treatment of injuries or medical conditions sustained through participation.
5. We further authorize the School District of South Milwaukee representative, or Midwest Orthopedic Specialty Hospital affiliated with Wheaton Franciscan Healthcare Sports Medicine Institute representative to take any necessary action in the case of an emergency. We further authorize transportation by Emergency Medical Service Personnel to an Emergency Management Facility and the EMF to treat the condition in the event that we are physically unable to give consent ourselves.
6. We understand that participation in co-curricular activities provided by School District of South Milwaukee may result in injury, some of which could result in catastrophic outcomes including, but not limited to; concussion, permanent paraplegia, or death. Participants hold the responsibility to perform only approved safe techniques in practices and games.
7. Participants/Parents/Guardians have been educated on the signs, symptoms and care of concussions and agree to abide by concussion protocols.
8. We accept all risks associated with participation while using our facilities or services.

It is the student's responsibility to read and follow all WIAA rules of eligibility. These rules are posted on the School District of South Milwaukee website (www.sdsm.k12.wi.us). Having been cautioned and warned, we sign this document voluntarily, intelligently and with full knowledge of its legal consequences. Furthermore, we release the School District of South Milwaukee, the members of the School District of South Milwaukee School Board, and their respective employees and agents and Midwest Orthopedic Specialty Hospital affiliated with Wheaton Franciscan Healthcare Sports Medicine Institute Representatives from any liability and or claims of negligence that may occur during participation in any practice and/or event which is in any way related to the co-curricular activity. We further understand that the School District of South Milwaukee does not provide health insurance on behalf of participants in such co-curricular activities, and that the responsibility for medical coverage for any injury or illness sustained as a result of participation does not lie with the District. We understand that this release will apply to myself, and personal representatives, heirs, and assigns.

Parent/Guardian Signature ____ Date _______________________

Student Athlete Signature ____ Date ______________