

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
Present Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Parents' Place of Employment \_\_\_\_\_  
Family Physician \_\_\_\_\_ Family Dentist \_\_\_\_\_  
Name of Private Insurance Carrier \_\_\_\_\_  
Policy Numbers and Address \_\_\_\_\_

1. 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.
2. I further 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 medication be made available.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_