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

Physical Date		20_		
NAMELast	First	Middle Initial	GRADE	DATE OF BIRTH
				Telephone
Parents' Place of Employment				
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				Telephone
Subscriber Member Name (Primary				
I hereby give my permission for I also attest to the fact that the a Pursuant to the requirements of ize health care providers of the sor practice, to disclose/exchange Principal, Athletic Director, Athlet of treatment, emergency care and tis recommended that informati	the above named student to practic above named student has had no in the Health Insurance Portability an student named above, including em e essential medical information reg tic Trainer, Team Physician, Team C nd injury record-keeping.	jury or illness serious enough to vid Accountability Act of 1996 and the ergency medical personnel and or arding the injury and treatment occurs, Administrative Assistant to and prescribed medication be man	varrant a medica the regulations p ther similarly tra of this student to the Athletic Dire	approved sports. If evaluation prior to participating this school year, romulgated thereunder (collectively known as "HIPAA"), it author ined professionals that may be attending an interscholastic even appropriate school district personnel such as but not limited to ctor and/or other professional health care providers, for purposes re-evaluation, contact your medical advisor before signing card.
SIGNATURE OF PARENT			n.	ATE
				AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
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WISCO	NSIN INTERSCHOLASTIC AT	THLETIC ASSOCIATION ALT		AR ATHLETIC PERMIT CARD
		,	SDADE	DATE OF BIRTH
NAMELast	First	Middle Initial	anauc	DATE OF BINTH
Present Address				Telephone
Parents' Place of Employment				
Family Physician		Fami	ily Dentist	
				Telephone
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				AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
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Physical Date		- 20_		
NAME	First		GRADE	DATE OF BIRTH
Last		Middle Initial		
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Parents' Place of Employment				
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 Pursuant to the requirements of ize health care providers of the s or practice, to disclose/exchange Principal, Athletic Director, Athlet of treatment, emergency care an It is recommended that informatic 	the above named student to practic bove named student has had no in the Health Insurance Portability and student named above, including eme e essential medical information region Trainer, Team Physician, Team C di nijury record-keeping.	jury or illness serious enough to verious and decountability Act of 1996 and the ergency medical personnel and or arding the injury and treatment of coach, Administrative Assistant to und prescribed medication be manually and prescribed medication be manually assistant to the coach, Administrative Assistant to the coach, and prescribed medication be manually assistant to the coach, and prescribed medication be manually assistant to the coach and the coach as the coach	varrant a medica the regulations pather similarly tra of this student to the Athletic Dire	approved sports. al evaluation prior to participating this school year. bromulgated thereunder (collectively known as "HIPAA"), I author ined professionals that may be attending an interscholastic even appropriate school district personnel such as but not limited to ctor and/or other professional health care providers, for purposes re-evaluation, contact your medical advisor before signing card.
SIGNATURE OF PARENT			D.	ATE
ALL STUDENTS PARTICIPATING IN	N INTERSCHOLASTIC ATHLETICS M	UST HAVE THIS ALTERNATE YEAR		AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION