Fill out **ALL** information on this page and one of the main boxes on page 2.

NAME_____ _____ _____

Last First M.I. Date Grade in School

ATHLETIC PERMIT AND LIABILITY WAIVER

This portion is to be filled out every year.

1. I hereby give my permission for my student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this form.
2. 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 on this form, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential 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.
3. I also attest to the fact that the student named on this form has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.

I, the undersigned, have adequate insurance and am willing to take full financial responsibility for any and all injuries sustained by my son/daughter while participating, whether it be in a practice session or in actual competition, in a WIAA or any other sponsored sport in the St. Mary's Springs Academy Athletic program.

I further knowingly and voluntarily waive any and all claims against and forever release the St. Mary's Springs Academy, its Board Members, Officers, Agents, Employees and Volunteers for any and all injuries sustained by my son/daughter with participating, whether it be in a practice session or in actual competition, in a WIAA or any other sponsored sport in the St. Mary's Springs Academy district Athletic program.

Parent/Legal Guardian Signature_____ Date_____

Printed Parent/ Legal Guardian Name _____

St. Mary's Springs Academy -- Athletic Code of Conduct

This portion is to be filled out every year.

I understand all of the rules and regulations of the St. Mary's Springs Academy Athletic Code of Conduct. I furthermore agree to cooperate with the school in enforcing the code for the betterment of all concerned.

Athlete Signature _____ Date_____

Parent Signature_____ Printed Parent Name_____

Sports _____

Activities _____

Wisconsin Interscholastic Athletic Association High School Athletic Eligibility Information

Parent-Athlete Rule of Eligibility

This portion is to be filled out every year.

I certify that I have read, understand, and agree to abide by all of the information contained in the WIAA Athletic Eligibility bulletin. I further certify that if I have not understood any information contained in that document, I have sought and received an explanation of the information prior to signing this statement.

Student/Athlete's Signature_____ Date_____

Parent/Guardian's Signature_____

A separate concussion acknowledgement form must be filled out and on file prior to the start of practice.

Athletic Alternate Year/ New Physical Page

Fill out name, age, address, etc., and **either** the Alternate Year **or** Athletic Permit box.

NAME_____ _____

Last First Middle Initial Date of Birth

Age_____ **Sex**_____ **Grade**_____ **School** _____ **Phone**_____

Present Address_____ **City**_____ **Zip**_____

********One of the two boxes must be completed and on file prior to the first practice********

Please note that a physical taken after April 1 is good for the next two years with this alternate waiver. Physicals taken before April 1 are good only for the remainder of that school year and during the following year with this alternate waiver. The school must still have a copy of the original physical on file, so new athletes or transfer students need to be prepared to supply the original physical.

WIAA ALTERNATE YEAR ATHLETIC PERMIT

ATHLETIC PERMIT AND LIABILITY WAIVER FROM PAGE ONE MUST BE SIGNED.

SCHOOL YEAR 20_____ - 20_____

NAME _____ GRADE _____ DATE OF BIRTH _____

Last First Middle Initial

Present Address _____ Telephone _____

PARENT: If there is any question that this student may not be healthy enough for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing. Always defer to the recommendations of your primary care physician when deciding whether or not to have a new physical. A new physical is required at least every two years by the WIAA in order to compete. Signing below indicates that my child is in good physical health and able to fully participate and has had a physical within in past two years which meets WIAA requirements.

Date of original physical _____

SIGNATURE OF PARENT _____ DATE _____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS ALTERNATE YEAR CARD OR A CURRENT PHYSICAL ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

--OR--

WIAA ATHLETIC PHYSICAL PERMIT

ATHLETIC PERMIT AND LIABILITY WAIVER FROM PAGE ONE MUST BE SIGNED.

SCHOOL YEAR 20_____ - 20_____

Physical examinations on April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the reminder of that school year and the following school year. If taking a new physical, be sure to fill out a Physical History Form prior to your doctor's visit and have your doctor complete the following after your examination.

☐ Cleared without restriction ☐ Cleared, with recommendation for further evaluation or treatment for:_____

☐ Not cleared for: All Sports Certain Sports:_____

Reason & recommendations:_____

_____

Signature of Licensed Physician (MD or DO) & (APNP or PA):_____

Address _____ City _____

State _____ Zip Code_____ Office Phone _____ Exam Date: _____

*****All students participating in Interscholastic Athletics must have this form on file at their school PRIOR TO PRACTICE OR PARTICIPATION.**

Concussion / Sudden Cardiac Arrest - Agreement Form

PARENT AGREEMENT

As a parent/guardian and as an athlete it is important to recognize the signs, symptoms, and behaviors of concussions and sudden cardiac arrest. By signing this form, you are stating that you have read the Department of Public Instruction's (DPI) and the Wisconsin Interscholastic Athletic Association (WIAA) Concussion and Head Injury information sheet and Sudden Cardiac Arrest Information sheet.

Parent Agreement:

I, _____ have read the DPI's Concussion and Head Injury Information sheet. I have had the opportunity to read more information about concussions on the Centers for Disease Control and Prevention's (CDC) websites. I understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me. I understand that my child cannot return to practice/play until they are evaluated by an appropriate health care provide and provide written clearance from the health care provider to their coach.

I understand concussions can have a serious effect on a young, developing brain and need to be addressed correctly.

I have read the Sudden Cardiac Arrest information sheet. I understand that my child should stop activity/exercise immediately if they have any warning signs of sudden cardiac arrest. I understand it is recommended if my child has any warning signs of sudden cardiac arrest while exercising, they have a medical examination before exercising or returning to participation in their sport. I understand that I or my child should report a family history of heart problems or warning signs of sudden cardiac arrest to the healthcare provider doing the medical examination.

I understand how to request at my cost the administration of an electrocardiogram, in addition to a comprehensive physical examination required to participate in a youth athletic activity. I understand the athletic director may be able to assist me.

_____ _____

Parent/Guardian Signature **Date**

ATHLETE AGREEMENT

As a parent/guardian and as an athlete it is important to recognize the signs, symptoms, and behaviors of concussions and sudden cardiac arrest. By signing this form, you are stating that you have read the Department of Public Instruction's (DPI) and the Wisconsin Interscholastic Athletic Association (WIAA) Concussion and Head Injury information sheet and Sudden Cardiac Arrest Information sheet.

Athlete Agreement:

I, _____have read the Concussion and Head Injury Information sheet. I have had the opportunity to read more information on concussions on the Centers for Disease Control and Prevention's (CDC) websites. I understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian.

I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must be evaluated by an appropriate health care provider and provide to my coach written clearance to participate in the activity from the health care provider before 5I may return to practice/play.

I understand that after a head injury my brain needs time to heal and that it may not heal properly if I return to practice/play too soon.

I have read the Sudden Cardiac Arrest Information sheet. I understand that I should stop activity/exercise immediately if I have any warning signs of sudden cardiac arrest and report the symptoms to my coaches and my parents/guardians.

_____ _____

Athlete Signature **Date**

STUDENT ATHLETE: MEDICAL INFORMATION AND EMERGENCY CONSENT FORM

PARTICIPANT'S NAME:		
ADDRESS:		
CITY:	ZIP:	PHONE:
PARENT/LEGAL GUARDIAN:		
ADDRESS:		
EMPLOYER:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
OTHER EMERGENCY CONTACT PERSON:		PHONE:

MEDICAL INFORMATION

FAMILY PHYSICIAN:	PHONE:
GROUP/ADDRESS:	
HOSPITAL OF PREFERENCE:	

INSURANCE INFORMATION

SUBSCRIBER:	GROUP NUMBER:
POLICY NUMBER:	COMPANY:
PRE-EXISTING MEDICAL CONDITIONS:	

I authorize the coaching staff to provide emergency medical treatment of any injury to or illness by my child if qualified medical personnel consider treatment necessary. I further authorize any qualified, licensed physician to render medical treatment which in his or her judgment may be deemed necessary in the care of (child's name) _____

PARENT/LEGAL GUARDIAN:	DATE:

PARENT/LEGAL GUARDIAN:	DATE:

Parent/Guardian Email Address: _____