WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

1. Examination taken after April 1 is good for the following **TWO SCHOOL YEARS.**
2. Examination taken before April 1 is good for the remainder of that **SCHOOL YEAR** and the following **SCHOOL YEAR.**

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

Grade _____ Age _____ Sex _____

School _____ City _____ State _____ Zip Code _____

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

Sports or school activities in which this student cannot participate are (if none – write NONE) _____

_____

SIGNATURE OF LICENSED PHYSICIAN* : _____ **OR APNP:** _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

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

* 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.

OVER

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 _____

Preparticipation Physical Evaluation

(Medical History to be Retained by Physician/Provider)

HISTORY

DATE OF EXAM _____

NAME (Last) _____ (First) _____ (Middle Initial) _____ DATE OF BIRTH _____

Grade _____ Age _____ Sex _____ School _____ Sport(s) _____

City _____ State _____ Zip Code _____ Telephone _____

Personal Physician _____

Explain "Yes" answer(s) below. Circle questions you don't know the answers to.

	Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____

Hepatitis B _____ Chicken Pox _____

FEMALES ONLY

16. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year? _____

Explain "Yes" answer(s) here _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete _____ Signature of Parent/Guardian _____ Date _____

Revised 5/99

Preparticipation Physical Evaluation

(Medical History to be Retained by Physician/Provider)

PHYSICAL EXAMINATION

NAME (Last)_____ (First) _____ (Middle Initial)_____ DATE OF BIRTH _____

HEIGHT_____ WEIGHT _____ % BODY FAT (optional) _____ PULSE _____ BP____ / ____ (____ / ____ , ____ / ____)

VISION R 20 / _____ L 20 / _____ CORRECTED: Y N PUPILS: EQUAL_____ UNEQUAL_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

☐ Not cleared for: _____ Reason: _____

Recommendations: _____

_____

_____

_____

Name of physician or APNP (print/type) _____ Date: _____

City _____ State _____ Zip Code _____ Telephone _____

Signature of physician: _____ MD/DO or APNP: _____