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

Physical Date		SCI	HOOL YEAR 20 20		
NAME			GRADE	DATE OF BIRTH	
	Last	First	Middle Initial		
Present Address				Telephone	
Parents' Place o	f Employment				
Family Physician		Family Dentist			
Name of Private Insurance Carrier				Telephone	
I hereby giv I also attest Pursuant to ize health c or practice, Principal, At of treatmen It is recomm	te my permission for the to the fact that the about the requirements of the state o	ne above named student to practic ove named student has had no in ne Health Insurance Portability an udent named above, including em essential medical information reg & Trainer, Team Physician, Team C injury record-keeping. n regarding your child's allergies a	d Accountability Act of 1996 and the regulations ergency medical personnel and other similarly tra arding the injury and treatment of this student to loach, Administrative Assistant to the Athletic Dire and prescribed medication be made available.		
SIGNATURE OF PARENT				DATE	
				AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION	