ATHLETIC PHYSICAL PARTICIPATION FORM

Name _____ **Date of Birth** _____
Last Name First Name Middle

Height _____ **Weight** _____ **Grade** _____ **Sex** _____

Part One – Physical Examination
(To Be Completed By A Licensed Physician)

List sport(s) this student cannot participate in _____
The above named student has been examined, and there is no contraindication to participating in

interscholastic athletics except as follows _____

_____

Signature of Examining Physician (M.D. or D.O. only) _____

Address _____ **City** _____ **Zip** _____

Telephone _____ **Date of Examination** _____ / _____ / _____
Month Day Year

☐ **Note: Place an X in the box at the left, <u>ONLY</u> if you are approving the student for <u>ONE(1) YEAR of competition</u> – otherwise, approval will be for TWO (2) YEARS of competition. All physical exams taken APRIL 1st and hereafter are valid for the following two school years. Exams taken before APRIL 1st are <u>ONLY</u> valid for the remainder of that school year and the following school year.**

Part Two – Parent / Guardian Permission

Parent / Guardian Name _____

Address _____ **City** _____ **Zip** _____

Home Phone _____ **Work Phone** _____

I hereby give permission for my son / daughter to practice, compete and represent the school in WIAA approved interscholastic sports. I further grant permission for my son / daughter to be given emergency care / treatment in the event of injury, as the result of athletic competition, by paramedics and / or by a licensed physician for the next two years.

Part Three – Athletic Insurance Coverage

I certify that our family health insurance policy is adequate in case of an emergency / injury, and therefore, decline to enroll our son / daughter in the student accident insurance plan made available through the school district, for the next two years.

_____ _____
Signature of Parent / Guardian **Date**