

Aurora BayCare

SPORTS MEDICINE

1160 Kepler Drive • Green Bay, WI 54311 • 920-288-5400

CONSENT FOR ATHLETIC TRAINING SERVICES and EMERGENCY MEDICAL TREATMENT

(Must be completed and signed by the athlete's parent or guardian)

RETURN TO THE: _____

Student's Name: _____ Date of Birth: _____

Student's Address: _____ City: _____

Parent (Guardian) Name: _____

Home Phone: _____

Father: Work Phone _____ Cell: _____

Mother: Work Phone _____ Cell: _____

In case of emergency and the absence of parent/guardian, please list two people you recommend we call:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

List any known allergies: _____

List any medications student is taking and why: _____

List any physical disabilities: _____

Additional Comments: _____

Name of Medical Insurance Company or Plan: _____

Policy Numbers: _____

Health Maintenance Organization (HMO)? Yes _____ No _____

If yes, what is your primary care facility: _____

CONSENT & AUTHORIZATION

I hereby authorize the employed or contracted staff of Denmark High School Athletic Department ("Department") (i.e., administrators, coaches, athletic trainers, team physician, and/or other assigned medical personnel) to provide athletic training services to my son/daughter/ward and to secure any necessary medical assistance on behalf of my son/daughter/ward. I further authorize these individuals to discuss my son/daughter/ward's medical condition with other health care personnel, which the Department deems appropriate. To the fullest extent permitted by law, I do hereby indemnify and hold harmless the Department, entities, and other persons who act in reliance upon this authorization. This document is valid for all years of student's enrollment at Denmark High School. Any changes to above information needs to be made with the athletic trainer and is up to the responsibility of the parent/guardian.

Parent/Guardian Signature: _____ Date: _____

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

Wisconsin Interscholastic Athletic Association – Parent/Guardian Permission Form
SCHOOL YEAR 20____ - 20____

NAME (Last)_____ (First)_____ (MI)_____ Grade_____

Last Physical Date_____ Date of Birth_____

Present Address_____ Phone Number_____

Parents Place of Employment_____

Family Physician_____ Family Dentist_____

Name of Private Insurance Carrier_____ Policy Number_____

Emergency Information: Allergies_____ Other Info (medication etc.)_____

Immunizations: _____ Up to date _____ Not up to date – specify_____

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 form.
2. I also attest to the fact that the above named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there under (collectively known as "HIPPA"), I authorize health care providers of the student named above, 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.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.
PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing.

SIGNATURE OF PARENT_____ Date_____

**PHYSICAL EXAMINATION TAKEN APRIL 1 AND THEREAFTER IS VALID FOR THE FOLLOWING TWO SCHOOL YEARS;
PHYSICAL EXAMINATION TAKEN BEFORE APRIL 1 IS ONLY VALID FOR THE REMAINDER OF THAT SCHOOL YEAR AND
THE FOLLOWING SCHOOL YEAR**

(The information below only needs to be filled out by a physician if a student does not have a current physical on file at the school)

Wisconsin Interscholastic Athletic Association – Physical Permit Form
SCHOOL YEAR 20____ - 20____

Name (Last)_____ (First)_____ MI____ Date of Birth_____

Present Address_____ Phone Number_____

Age____ Sex____ Grade____ School_____ City_____

____ Cleared without restrictions _____ Cleared with recommendations for further evaluation for treatment for: _____

Not cleared for: _____ All Sports _____ Certain sports: _____ Reason_____

Recommendations: _____

SIGNATURE OF LICENSED PHYSICIAN (MD or DO)*: _____ Or APNP: _____

Address_____ City_____ State____ Zip Code_____

Phone Number_____ Date of Examination_____

*Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature