WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ATHLETIC PERMIT CARD

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

Grad. Year	Date of Birth
Grade	Age
Sex	Student ID #
School	

Date of Examination

_____
Signature of Licensed Physician* or APNP

**Physician 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.*

Current Address	Parents' Places of Employment
Family Physician	Family Dentist
Name of Private Insurance Carrier	Policy Numbers & Address

1. I hereby give my permission for the above-named student to practice and compete and represent the school in WIAA approved sports.
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 Date

WIAA Green cards cannot be forwarded to other schools unless the Authorization for Exchange of Health or Education Information (HIPAA Compliant) form has been completed.

RUSD Athletic Code, Rules, Policies & Procedures

Pertinent health issues, allergies, medications that you wish to voluntarily share with tour child's coach should be indicated on the yellow athletic emergency card. You must notify the school in writing if there is a change or cancellation of medication, and you further agree to comply with the RUSD policy regarding medication administration. School district employees who obtain information from a student's healthcare record must keep the information confidential and may not disclose identifying information about any child whose patient healthcare records are released.

We have received, read, and understand the Racine Unified School District and WIAA's eligibility, ruse, transfer, concussion and medication information, Parent/Student Athletic Handbook & Code of Conduct. We understand that all athletes are expected to abide by these rules, policies, and procedures, and those individual team polices presented by the coaches and will be subject to penalty if found in violation.

Athletes are responsible for proper care of uniforms and equipment and parents will be held financially responsible for damaged or missing uniforms and equipment. Students may not participate further until this responsibility is met.

User Fees will not be refunded for any reason other than being cut from the sport. Refunds must be requested for the Activities Office.

Insurance Waiver

To Parents: One of the requirements for participation in Interscholastic athletics is that every athlete be insured against injury. For this purpose the school district makes available standard insurance through Student Assurance Services. A boy or girl who is already adequately insured by his/her family may be allowed to participate only if one of the parents waives the required insurance offered through the school. Your signature on this form constitutes such a waiver signifies your son or daughter does have accident insurance coverage for the dates of participation. It is further understood that the school district does not assume any liability or health and accident expenses and such responsibility will be that of the parent or guardian.

WE HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

_____
Parent/Guardian Signature Student Signature

_____
Date Insurance Company

RUSD CONCUSSION STATEMENT CARD

In accordance with Wisconsin's Sidelined for Safety Act 172, we, the undersigned, acknowledge having received education about the signs, symptoms and risks of sport related concussion. We understand that students are prohibited from any participation until this form is completed. And returned the Activities Office.

I acknowledge my responsibility to report to my coaches, parent(s)/guardian(s) any signs or symptoms of a concussion and agree to abide by all RUSD concussion protocols.

_____

Printed Name of Student/Athlete Signature Date

I, the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs, symptoms and risks of sport related concussion and agree to abide by all RUSD concussion protocols.

_____

Printed Name of Parent/Guardian Signature Date

Concussion & Cardiac Arrest Agreement

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.

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 healthcare provider and provide written clearance from the healthcare provider to their coach.

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 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.

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 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 healthcare provider and provide to my coach written clearance to participate in the activity, from the healthcare provider, before I 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 Student 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

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

School Year	Physical Date	
Name (Last, First Middle Initial)	Grade	DOB
Address		Telephone
Parents' Place of Employment		
Family Physician	Family Dentist	
Name of Private Insurance Carrier	Telephone	

Subscriber Member Name (Primary Insured)

1. I hereby give my permission for the above-named student to practice and compete and represent the school in WIAA approved sports.
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 Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as HIPPA), I authorize healthcare 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 healthcare 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 card.

_____

Parent Signature Date

All students participating in interscholastic athletics must have this alternate year card on file at their school, prior to practice or participation.

RACINE UNIFIED
SCHOOL DISTRICT

Athletics Emergency Card

(A new card must be completed for each sport)

Athlete's Name		Sport
Address		Zip Code
Date of Birth	Academy	Grade

Parent Contact Information

Name	Email Address
Cell/Home Phone Number	Work Phone Number

Person to notify if parents are not available

Name	Phone

Medical Information – Please list all important medical information

Family Doctor's Name	Preferred Hospital
Allergies	Medication and dosage
Health Conditions and other important medical information	

I hereby give permission for the above-named student to be given immediate emergency care in case of injury as the result of athletic competition by the medical professional present.

_____

Parent/Guardian Signature Date