

KENOSHA UNIFIED SCHOOL DISTRICT ATHLETIC PERMISSION FORM

Please enter your insurance information into these two fields:

Insurance Carrier: _____ Policy Number: _____

Permission to Participate

I hereby give my permission for the above-named student to practice, compete, and represent the school in WIAA regulated interscholastic sports except any restrictions as noted on the current, effective physical examination card as completed by a licensed physician or advanced practice nurse prescriber. This letter shall be provided to each student when they sign up to participate in a sport. No athlete will be permitted to participate until this form is signed and on file with building athletic director. Plus, this form serves as a notification of parental (guardian) permission to participate in the sport of: _____ . (Drop Down Selection)

Responsibility to Return All School-Issued Uniforms/Equipment

I agree to be financially responsible for the safe return of all athletic uniforms and equipment issued to him/her. I understand that my son/daughter is responsible for any uniform or equipment that is assigned specifically to him/her, and agree to reimburse the school the actual replacement value of the uniforms/equipment in the event that they are lost or stolen. I understand that failure to reimburse KUSD in a timely fashion could affect my son/daughter's athletic eligibility.

Permission for Emergency Medical Care and Conveyance

I further grant permission for my son/daughter, named above, in case of injury as a result of athletic participation, to be given emergency attention/care by the coaching staff, athletic trainer, the team physician or any other physician present, and to be conveyed to an emergency medical facility, if needed. I understand that all medical costs that could occur from such conveyance and subsequent treatment are the sole responsibility of the parents/guardians, and I understand that KUSD will assume no liability for the cost of said conveyance or treatment.

Informed Consent

I understand that injuries could occur as a result of participation in athletics. I understand that these injuries could include minor injuries such as bruises or abrasions, muscle strains, sprains, or broken limbs. I understand that it is possible that a catastrophic injury could occur rendering my son/daughter paralyzed, and that death could also occur as a result of a catastrophic injury.

Insurance Waiver

I certify that I have adequate insurance coverage on the above-named student to cover medical expenses in the event of an athletic-related accident or injury.

Signature

By signing this form I am attesting to the fact that I understand and agree to all conditions set forth on this form and that if I have not understood any information, I have sought and received an explanation, and I am fully aware that I am granting permission for the above-named student to participate in the KUSD Athletic Program.

Parent/Guardian Signature

Date

Athlete Signature

Date

SIGNING THIS STATEMENT.

Parent's/guardian's signature

Date

One agreement must be signed each year for all student participation in Categories 1, 2, and 3 activities.

Please list the activities your student will be involved in during the present school year.

SPORTS	ACTIVITIES

Coaches/advisors must retain a signed copy of this form in their files for each student involved in their activity.

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.

Parent Agreement:

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 health care provider and provide written clearance from the health care provider to their coach.

I understand concussions can have a serious effect on a young, developing brain and need to be addressed correctly.

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 a 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.

Athlete Agreement:

I have read the Concussion and Head Injury Information sheet. I have had the opportunity to read more information on 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 health care provider and provide to my coach written clearance to participate in the activity from the health care 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 Sudden 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 _____

PREPARTICIPATION PHYSICAL EVALUATION MEDICAL ELIGIBILITY FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

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

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex assigned at birth (F, M or intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

Medically eligible for certain sports

Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical exam findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*: _____

Clinic Name _____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

* PHYSICIANS may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Medications _____

Other Information _____

Immunizations Up to date (see attached documentation) Not up to date - specify _____

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

- 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.
- Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), 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.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____