SCHOOL DISTRICT OF WEST ALLIS-WEST MILWAUKEE, ET AL.

ATHLETIC PARTICIPATION FORM

_____ Date of Birth_____
Last Name First Middle

Height_____ Weight_____ Grade_____ Age_____ Sex_____

PART I –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: _____

_____

To The Examining Physician

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NOTE—Place an X in the box at the left, ONLY if you are approving the student for ONE (1) YEAR of competition—otherwise, approval will be for TWO (2) years of competition.
All physical exams taken April 1 and hereafter are valid for the following two school years; exams taken before April 1 are only valid for remainder of that school year and the following school year.

Signature of Examining Physician (M.D. or D.O. Only):_____
Address: _____City:_____Zip:_____
Telephone: _____Date of examination:_____
(Month/Day/Year)

PART II—PARENT/GUARDIAN PERMISSION

Parent/Guardian Name: _____
Address: _____City:_____Zip:_____
Home Telephone: _____Work Telephone:_____
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 III—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)