WEYAUWEGA-FREMONT ATHLETIC AND ACTIVITY INFORMATION CARD

THIS FORM MUST BE FILED EVERY YEAR <u>BEFORE</u> PARTICIPATION CAN BEGIN IN ANY ATHLETIC PROGRAM.

1. Examination taken ***after April 1*** is good for the following **<u>TWO SCHOOL YEARS.</u>**
2. Examination taken ***before April 1*** is good for the remainder of that **<u>SCHOOL YEAR</u>** and the following **<u>SCHOOL YEAR</u>**.

<u>ALTERNATE YEAR CARD</u> – School Year 20_____-20_____

NAME _____ **GRADE**_____ **GENDER: MALE FEMALE**
Last First M.

SPORT PARTICIPATING IN: _____ _____ _____
FALL **WINTER** **SPRING**

DATE of Student's Most Recent Medical Sports Physical Examination: _____
(If unsure, check with the Activities Office for date on last card on file.)

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

PARENT: If there is any question that this student may not be qualified for athletic/activities competition without, at least, a partial re-evaluation, contact your medical advisor before signing this card.

_____ **DATE**_____
(Signature of Parent)

EMERGENCY INFORMATION FOR _Student's Name-→_____

PARENT NAME _____
LAST FIRST HOME PHONE NUMBER ALTERNATE PHONE NUMBER

HOME ADDRESS_____CITY_____ZIP_____

PHYSICIAN _____ADDRESS_____PHONE_____

INSURANCE COMPANY_____POLICY OR GROUP NO._____

ALERGIES OR ALLERGIC REACTIONS_____

KNOWN SIGNIFICANT MEDICAL CONDITIONS_____

IN CASE OF EMERGENCY, ATTEMPT TO CONTACT A PARENT AT HOME OR AT WORK. IF WE CANNOT BE REACHED, ATTEMPT TO CONTACT THE ALTERNATE LISTED BELOW:

ALTERNATE NAME_____PHONE_____RELATIONSHIP_____

PERMISSION IS HEREBY GRANTED TO THE ATTENDING PHYSICIAN TO PROCEED WITH ANY MEDICAL TREATMENT. I UNDERSTAND THAT AN ATTEMPT WILL BE MADE BY THE ATTENDING PHYSICIAN TO CONTACT ME IN THE MOST EXPEDITIOUS WAY POSSIBLE. PERMISSION IS ALSO GRANTED TO THE ATHLETIC TRAINER TO PROVIDE THE NEEDED EMERGENCY TREATMENT TO THE ATHLETE PRIOR TO HIS/HER ADMISSION TO THE MEDICAL FACILITIES.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

<u>INSURANCE</u>

All students should have adequate Insurance Coverage. Your signature below signifies that you have adequate insurance or will assume the cost of any injuries incurred in participation. The Weyauwega-Fremont School District does not sponsor an insurance plan. The school district makes available an insurance plan through a local agency. These forms are located in the Weyauwega-Fremont School Offices.

_____ _____
I agree to/understand the above insurance information.

Parent Signature_____ _____
Date

WEGA-FREMONT SCHOOL DISTRICT
Weyauwega-Fremont Schools
Co-Curricular Code of Conduct, WIAA Rules of Eligibility and Concussion Information Receipt

This form must be completed and returned to the Activities Office *prior* to participation in any co-curricular activity.

Student Section

I have received a copy, read and understand the provisions of the Co-Curricular Code of Conduct and the WIAA Rules of Eligibility.

As a student, I understand that my participation in co-curricular activities is a privilege and, therefore, agree to be bound by the Weyauwega-Fremont Co-Curricular Code of Conduct. I also certify that I have read, understand, and agree to abide by all of the information contained in the WIAA Rules of Eligibility Bulletin (HS Only) and ***Concussion Signs and Symptoms information document. I also acknowledge my responsibility to report to my coaches, parents/guardians any signs or symptoms of a concussion.*** I further certify that if I have not understood any information contained in the document, I have sought and received an explanation of the information prior to signing this statement.

Student Name: (print clearly)_____ **Student Signature:** _____

Parent Section

I have received a copy, read and understand the provisions of the Co-Curricular Code of Conduct and the WIAA Rules of Eligibility.

As a parent, I understand that my son or daughter's participation in co-curricular activities is a privilege and, therefore, agree that they are to be bound by the Weyauwega-Fremont Co-Curricular Code of Conduct. I also certify that I have read, understand, and agree to abide by all of the rules contained in the WIAA Rules of Eligibility Bulletin (HS Only) and ***Concussion Signs and Symptoms information document***. I further certify that if I have not understood any information contained in the document, I have sought and received an explanation of the information prior to signing this statement. I will see that these rules and regulations are followed. I give my permission to have first aid and emergency treatment given to my child if such assistance is required. I give permission for the Activities Office to release my home address and phone number to organizations supporting activities in the Weyauwega-Fremont School District. This agreement is binding through my son or daughter's graduation from high school.

Parent Name: (print clearly)_____ **Parent Signature:** _____

THEDA CARE
AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Athlete's Name	**Date of Birth**	**Address**

Authorizes information to be released from:

Theda Care
122 E. College Ave.
Appleton, WI 54911

Information Released to: (Officials of the school I attend, including coaching staff and Athletic Directors who are involved in my sporting events).

Weyauwega-Fremont Schools
510 East Ann Street
Weyauwega, WI 54983

Information to be released includes: All information concerning my health that impacts my ability to participate in sports. This may include information about injuries (such as sprains, strains), surgeries (such as ACL reconstruction, rotator cuff repair), concussions (ImPACT test results) or medical conditions (such as asthma).

Need for the disclosure: The purpose of the release of this information is to inform the coaching staff of my health related limitations and abilities to continue to participate in sporting events. Also to provide the coaching staff with information about my injury to help me participate in sporting events safely.

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to inspect or Copy the Health Information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do so I must be provided with a signed copy of the form. Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and or organization (s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to withdraw this Authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. EXPIRATION DATE: This authorization is good for one year from the date signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

Parent Signature: _____ **Date:** _____