Providence Academy
Wisconsin Interscholastic Athletic Association
Alternate Year Card

NAME_____
Last First Middle Initial

GRADE_____ DATE OF BIRTH_____

Present Address_____ Telephone_____
Parent's Place of Employment_____
Family Physician_____ Family Dentist_____
Name of Private Insurance Carrier_____
Policy Number and Address_____

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 card.
2. I further grant my permission for any medical records pertaining to the health of the above named student be made available as necessary to the proper school district personal and appropriate health care provider, including emergency medical personal.
3. I give permission for the above named student to be evaluated and treated by the Certified Athletic Trainer for injuries incurred during Providence Academy athletic participation. I further permit the Certified Athletic Trainer to discuss the injuries with appropriate medical and school district personnel.
4. I have received forms that include rules, regulations, and policies regarding participation in Interscholastic Athletics. I am aware of the results of any violation of the athletic code.
5. I understand Providence Academy does not provide accident, medical, or dental insurance for student athletes. Providence Academy encourages all parents or guardians to provide adequate accident, medical, or dental insurance for their children.
6. I certify that the High School Athletic Eligibility Information Bulletin has been given to me and that extra copies are available in the office for my reference. I certify that I have read, understand, and agree to abide by all of the information contained in this bulletin. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

PARENT/GUARDIAN: 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 this card.

_____ **Date**_____
(Signature of Parent/Guardian)

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(Signature of Student/Athlete)