Yearly Athletic Form

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT J.R. GERRITTS MIDDLE SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Name: ____

Address: ____

Home Phone:____

Date of Birth: _______________ Grade: _______ Gender: ________

Doctor: ____________________________ Phone: ______________

Dentist: ____________________________ Phone: ______________

J. R. Gerritts Middle School
545 S. John St.
Kimberly WI 54136
920-788-7905
Fax 920-788-7914

Name of Private Insurance Carrier ____

Policy Numbers and Address____

By signing below,

1. I hereby give my permission for the above named student to practice, compete, and represent J.R. Gerritts Middle School approved interscholastic sports except those restricted on this card.

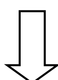
2. I further grant permission for any medical records pertaining to the health of the above named student to be made available as necessary to the proper school district personnel and appropriate health care providers, including emergency medical personnel. It is recommended that information regarding your child's allergies and prescribed medication be made available.

3. I have read, understand, and signed the JRG CO-CURRICULAR CODE.

4. I hereby authorize the treatment, administration of anesthesia and/or surgical treatment(s) for my minor child ___________________________, in the event of a medical situation occurring during my absence or when the hospital or physicians(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child____.

____ ____________________________

Signature of Parent or Guardian **Date**



7TH GRADE STUDENTS: This section MUST be completed by physician.
8TH GRADE STUDENTS: If physical form on file is CURRENT, ONLY PARENT SIGNATURE IS REQUIRED

Examination remains good for **TWO** years following the date of the examination.

This form must be signed by physician and on file at your student's school office prior to participation in interscholastic athletic activities.

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

Sports or school activities in which this student **CANNOT** participate are: ____________________________________.

Date of Examination: _________________________________

SIGNATURE OF LICENSED PHYSICIAN or APNP: __________________________________

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

Address____________________________ City______________________ State __________