ALL BOYS AND GRILS PARTICIPATING IN INTERSCOLASTIC ATHLETICS MUST HAVE THIS SHEET ON FILE A THE SCHOOL OFFICE COMPLETELY BILLED OUT AND ATHLETIC PARTICIAPTION FEE PAID BEFORE THEY BE ABLE TO PRACTICE.  1. PHYSICAL CARD — must be filled out by a physician or physician assistant  LAST NAME FIRST NAME INITIAL D.O.B. AGE SEX  ADDRESS CITY PHONE NO.  Cleared without restrictions Cleared, with recommendation for further evaluation or treatment for:  Signature of licensed Physician/P.A: Phone  Address: City, State, Zip Date:  2. ALTERNATE YEAR ATTE ETIC PERMIT CARD (USE AFTER PHYSIAL YEAR ONLY)  Sindent Name  Last name Exist Name Injury  D.O.B. Age Sex  Double Sex	Physicals given good for 2 years		ST. MARTIN LUI ATHLETIC PARTIC	THERAN SCHOOL CIPATION FORM		
THE SCHOOL OFFICE COMPLETELY FILLED OUT AND ATHLETIC PARTICIAPTION FEE PAID BENORS THEN BE ABLE TO PRACTICE.  1. PHYSICAL CARD — must be filled out by a physician or physician assistant  LAST NAME FRST NAME INITIAL D.O.B. AGE SEX  ADDRESS CITY PHONE NO.  Cleared without restrictions Cleared, with recommendation for further evaluation or treatment for:  Signature of licensed Physician/P.A: Phone  Address: City, State, Zip Date:  2. ALTERNATE YEAR ATTELETIC PERMIT CARD (USE AFTER PHYSICAL YEAR ONLY)  Sindent Name Last name Initial  D.O.B. Age Sex	20S0	CHOOL YEAR			Grade	
ADDRESS  CITY PHONE NO.  Cleared without restrictions  Cleared, with recommendation for further evaluation or treatment for:  Signature of licensed Physician/P.A:  Phone  Address:  City, State, Zip  Date:  2. ALTERNATE YEAR ATTALETIC PERMIT CARD (USE AFTER PHYSIAL YEAR ONLY)  Student Name  Last name  First Name  Initial  D.O.B. Age  Sex	THE SCHOOL OF BE ABLE TO PRA	FFICE COMPLETELY ACTICE.	FILLED OUT AND AT	HLETIC PARTICIAPIJO	N FEE PAID DI	EET ON FILE AT EFORE THEY WILL
Cleared without restrictions  Cleared, with recommendation for further evaluation or treatment for:  Signature of licensed Physician/P.A:  Phone  Address:  City, State, Zip  Date:  2. ALTERNATE YEAR ATTN_ETIC PERMIT CARD (USE AFTER PHYSEIAL YEAR ONLY)  Student Name  Last name  Last name  D.O.B. Age  Sex	LASTNAME	FIRST NAME	INITIAL	D.O.B.	AGE	SEX
Signature of licensed Physician/P.A:  Address:  City, State, Zip  Date:  2. ALTERNATE YEAR ATTALETIC PERMIT CARD (USE AFTER PHYSETAL YEAR ONLY)  Student Name  Last name  Last name  D.O.B. Age  Sex	ADDRESS		CITY	PHONE NO	),	
Address:	Cleared withou	it restrictions _	Cleared, with recomm	endation for further evaluati	on or treatment f	or:
2. ALTERNATE YEAR ATHLETIC PERMIT CARD (USE AFTER PHYSCIAL YEAR ONLY)  Student Name  Last name  D.O.B. Age  Sex	Signature of licensed	Physician/P.A:		Phone		
2. ALTERNATE YEAR ATRLETIC PERMIT CARD (USE AFTER PHYSOIAL YEAR ONLY)  Student Name  Last name  D.O.B. Age  Sex	Address:		City, State, Zip		Date:	
Student Name  Last name  D.O.B. Age  Sex						
D.O.B. Age Sex	2. ALTERNATE	YEAR ATHLETIC	PERMIT CARD (US	E AFTER PHYSOTAL	YEAR ONL	·¥)
WITA A conveyed specific Teles affect to the fact that the above parred student	Student Name	Last name	Eirst Name	Initial		
hereby give my permission for the above named student to compete and receivent the school WIAA approved sports. I also attest to the fact that the above named student as no injury or illness serious enough to warrant a medical evaluation per to participating this school type. I further grant permission for any medical records pertaining to be health of the above named student be made available if necessary to the proper school district personne. "HIPPA" Parent: If there is any question that this student may not a qualified for athletic competition without, at least, a partial evaluation, contact your medical advisor believes igning this sheet.		D,O.B.	Age	Sex		
	hereby give my permission for as no injury or illness serious on the health of the above named so a qualified for athletic competi	or the above named student to cenough to warrart a medical evenuent be made available if nection without, at least, a partial.	ompete and research the school of aluation pair to participating this essay to the proper school district evaluation, contact your medical	WIAA approved sports. I also attes school year. I further grant permissic personne "HIPPA" Parent; If there I advisor believe signing this sheet.	t to the fact that the a on for any medical re- e is any question that ,	above named student cords pertaining to this student may not
Signature of Parint/ or Legal Guardian Date	Signatur	e of Parint/ or Legal Gua	ardian	Date	Take .	
	.//				Sell line	
	. 12					

## 3. PARENT/GUARDIAN INSURANCE INFORMATION (required)

Parents Name				
	Address & Phone Number			
Parents Place of Employment				
Name of Insurance Carrier				
Address				
Policy Number		J. J. Children States		
Family Physician	Dentist			
Name of InsuranceCarrier		olicy Number		
Address				
I, hereby give my permission for the above named studer as a parent/legal guardian, I agree to be financially responanced above to be given immediate emergency care in c	nsible for the safe return of all athletic Equipment is	sued to him/her/ I further grant permission for my son/daug		
********	************	**************************************		
My student and I have received and read the f curricular events at St. Martin Lutheran School	following information needed for the above ol. This information includes:	re named student to participate in athletic and ex		
Please check:				
Athletic Booklet				
Sports Policy				
•				
Parent and Student Signature:		a. a feither		
The state of the s		*		
- N				
**********	************	*********		
Office use only:				
Basketball (Boys)	Softball	Volleyball		
Basketball (Girls)	Cheerleading			
	₹.	4		
Middle School Offerings:		***************************************		
Cross Country	Track	. Football		
		10 10		
		14 m		