UNIVERSITY OF WISCONSIN
Fox Valley
A Campus of the University of Wisconsin Colleges

Department of Physical Education and Athletics
920.832.2643 (office) 920.832.2674 (fax)

University of Wisconsin Colleges

Athletic Medical Certification

The University of Wisconsin Colleges requires that all individuals provide written proof that they are physically qualified to participate in intercollegiate athletics.

_____

* I, Doctor _____ (Medical Doctor) certify that _____ is physically qualified to participate in intercollegiate athletics for the 20___ - _____ academic year.

_____ (Doctor's signature)

_____ (Doctor's address)

_____

_____ (Date)

* Note to physician: The University of Wisconsin assumes that you have recently examined this individual, and that this medical examination is the basis for your certification.

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Medical Treatment Consent/Clearance Form
For Student Athletes

Name: _____ *Date of Birth:* _____
Address: _____ *City:* _____ *Zip:* _____
Home Phone: _____ *Alternate Phone:* _____
Sports Participating in: _____

In an emergency contact:
Name: _____ *Phone:* _____
Relationship: _____
Doctor: _____ *Phone:* _____
Known allergies: _____

Any medications?
*Short term medications:*_____ *reason:*_____
Routine/ongoing meds: _____ *reason:*_____
*As needed medication (ex. Asthma inhalers)*_____ *reason:* _____
(Please attach additional pages if needed)

Any known significant medical conditions: ___ Diabetes ___ Heart Disease ___ Asthma
Other: _____

Any head injury or concussions? (please indicate # of injuries and year(s) occurred):
_____

Insurance Company: _____ *Policy Number:*_____
Responsible Party: _____

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) in the event of a medical situation occurring when I am unable to give consent, or when the hospital or physician is unable to reach my emergency contact. This authorization extends to any hospital or physicians office and both physician and nursing personnel within the hospitals or physicians office(s), as well as any physician office, medical authorities, and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary. I also give permission to involved school personnel (ex. Coach, assistant, or Licensed Athletic Trainer) to seek needed medical attention by nearest physician and/or hospital.

Signature: _____ *Date:*_____

Witness: _____ *Date:*_____