



Department of Physical Education and Athletics

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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.

FOX VALLEY

A Campus of the University of Wisconsin Colleges

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: _____