St. Paul Athletic Permit Card

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First)_____ (Middle Initial) _____

Date of Birth_____ Age ____ Sex ____ Grade ____ Telephone _____

Present Address _____ City _____

☐ Cleared without restriction ☐ Cleared, with the following qualifications:_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)*: _____

Address: _____ City: _____ Zip _____

Telephone _____ Date of Examination: _____

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

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Student's Name _____

Parents' Place of Employment _____

Family Physician _____ Dentist _____

Name of Private Insurance Carrier _____ Tele: _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Other information (medication, etc.) _____

Immunizations ☐ Up to date ☐ Not up to date (specify)_____

1. I hereby give my permission for the above named student to practice and compete and represent the school in approved sports except those restricted on this card.
2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there under (collectively known as "HIPPA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school personnel such as but not limited to: Principal, Athletic Directors, Team Coach, and/or other professional health care providers, for the purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____