UNIVERSITY OF WISCONSIN
Fond du Lac
A Campus of the University of Wisconsin Colleges

Department of Physical Education and Athletics
Phone: 920-929-1178 (office)
Fax: 920-929-7640

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 at the University of Wisconsin – Fond du Lac.

I, Doctor _____ (Medical Doctor) certify that

_____ (athlete's name) is physically qualified to participate in

Intercollegiate Athletics for the 20__ - _____ academic year.

_____ (Doctor's Signature)

_____ (Doctor's Address)

_____

_____ (Date)

* Note to Examining Physician: *The University of Wisconsin – Fond du Lac assumes that you have recently examined this individual, and that this medical examination is the basis for your certification and signature on this document.*

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Medical Treatment Consent/Clearance Form
- For Student-Athletes

Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____
Home Ph: _____ Alt. Ph: _____
Sports Participating In: _____

In an Emergency Contact:
Name: _____ Phone: _____
Relationship: _____
Doctor: _____ Phone: _____
Known Allergies: _____

Medications?
Short Term Medications: _____ Reason: _____
Routine/Ongoing Meds: _____ Reason: _____
As Needed Medication (ex. Asthma inhalers) _____ Reason: _____
* Please attach additional pages/information if needed *

**** Any known significant medical conditions*: (*Ex. Diabetes, Heart Disease, Asthma, etc.*):**
_____

**** Any head or concussions*? (P*lease indicate # of injuries and year(s) occurred*):**
_____

Insurance Company: _____ Phone: _____
Responsible Party: _____ Phone: _____

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:* _____

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