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.

* Member of the Wisconsin Collegiate Conference
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? (Please 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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