

**MUKWONAGO HIGH SCHOOL
ATHLETIC PARTICIPATION FORM**

ALL BOYS AND GIRLS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS FORM ON FILE AT THE SCHOOL
PRIOR TO THE FIRST PRACTICE

PARENT OR GUARDIAN PERMISSION

Student Name: _____ Grade: _____

Birthdate: ____/____/____

The school board of the Mukwonago School District requires that all athletes have insurance coverage prior to any athletic practice or competition. If your son or daughter already has medical insurance coverage, you should state the insurance company and policy number below. If your son/daughter does not have medical insurance coverage, First Agency, Inc. is available to all participants. (Registration forms are available at the Office.)

I have coverage with _____ Policy # _____

I elect First Agency Inc. forms available at www.masd.k12.wi.us/parents-students/masd-forms.cfm

In the event of an injury during practice or competition, I grant permission for my son/daughter to be given immediate care and transported if necessary.

- I agree that my son/daughter is to be responsible for all equipment issued to him/her, and to pay for any items, which are lost or damaged.
- I have read the MHS athletic code of conduct. (Available on www.masd.k12.wi.us or picked up at the athletic office).
- I have read the high school athletic eligibility information bulletin (available at www.wiaawi.org)
- I support the athletic code of Mukwonago High School and agree that my son/daughter is to abide by this code. Furthermore, I agree to cooperate and assist with enforcement of the code of conduct.
- I have read and understand the preceding and give permission for the above named student to practice, compete, and represent Mukwonago High School in WIAA approved interscholastic sports except if restricted by a physician.

Parent/Guardian Signature: _____ Date: _____

Student Contract:

- I agree to be responsible for all equipment and fund raising items issued to me. I will pay for any items which are lost or damaged. Furthermore, I understand that I will not be eligible for athletic participation until all such delinquencies are cleared up.
- I have read the high school athletic eligibility information bulletin (available at www.wiaawi.org)
- I have read the Mukwonago High School athletic code of conduct. I agree to abide by the code and cooperate with the school in the enforcement of this code. Copies available in the athletic office or online.

Dated: _____ Student Signature: _____

ALL DUE FIRST DAY OF PRACTICE

**Current physical on file, participation form & \$100.00 participation fee - - -
(If cut sport \$100 due FIRST practice after cuts)**

Check any/all sports you plan to participate in:

FALL

- Football
- FB Cheerleading
- Cross Country
- Girls Golf
- Dance
- Field Hockey (no user fee)
- Boys Soccer
- Girls Swimming/Dive
- Girls Tennis
- Volleyball

Participation Fee:

\$100.00 per sport - Maximum per household is \$400.00

Individual max \$300.00

Fee must be paid first day of practice (or 1st practice after cuts) .

Checks made out to MHS or pay online

WINTER

- Basketball
- BB Cheerleading
- Gymnastics
- Hockey (no user fee)
- Ski Team(no user fee)
- Boys Swimming/Dive
- Wrestling

SPRING

- Baseball Softball
- Boys Golf Boys Tennis
- Girls Soccer Track
- Girls LaCrosse Boys LaCrosse
(no user fee LaCrosse)

_____	Amount Paid	\$100	_____	_____
Sport			Date	Ck #/Cash/Cr
_____	Amount Paid	\$100	_____	_____
Sport			Date	Ck #/Cash/Cr
_____	Amount Paid	\$100	_____	_____
Sport			Date	Ck #/Cash/Cr
_____	Amount Paid	\$100	_____	_____
Sport			Date	Ck #/Cash/Cr

Check this box if this is an alternate year physical. (Valid physical on file at MHS after April 1ST)

A physical examination taken **after April 1st** is good for the following two school years. A physical examination taken before April 1st is good for the remainder of that school year and the following school year.

The named student on the first page has been examined and may participate in interscholastic athletic activities except as follows:

(If none, write "none") _____

If student is restricted or disqualified, please indicate:

If approved for only one year of competition, please indicate: _____

Signature of licensed physician, surgeon, physician assistant or nurse practitioner

Address _____

City/State/Zip _____

Phone _____

Date of Exam _____