

**Valley City State University  
Athletic Insurance Agreement  
Informed Consent and Assumed Risk  
Permission to Treat**

**Medical Insurance.** Valley City State University Athletic Department and the North Dakota College Athletic Conference requires that all individuals **must show proof** that they are covered by a family or individual health and accident policy **before** they are allowed to practice or participate in any sport.

**Name of insured:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Group Number (if applicable):** \_\_\_\_\_

**Name of Insurance company:** \_\_\_\_\_

**Address of insurance company:** \_\_\_\_\_

\_\_\_\_\_  
**Owner of Policy:** \_\_\_\_\_

I attest that the afore mentioned student is covered by the listed policy and that the policy provides for medical and or hospital expenses resulting from accidental injuries that may be incurred while participating in, practicing for and traveling to or from intercollegiate athletic contests. This policy is, and will remain, in effect during the current school year and athletic seasons. If for some reason the coverage is no longer in effect or is terminated I will notify the Valley City State University Athletic Department. I understand that I am personally responsible and obligated for any medical expense this policy may not cover. I am also aware that Valley City State University is not responsible for the cost of my medical care.

**Date:** \_\_\_\_\_ **Athletes signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian:** \_\_\_\_\_

**Informed Consent.** I understand that there is a certain amount of risk associated with athletic participation. While competing in athletics at Valley City State University, I may suffer injuries such as fractures, sprains, strains, contusions, lacerations, abrasions, or other injuries. I may even suffer severe injuries, brain injuries, paralysis or death. I am aware of and understand the risks of athletic participation. I am a willing participant and assume such risks as described.

**Date:** \_\_\_\_\_ **Athletes signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian:** \_\_\_\_\_

**Permission for Medical Treatment.** In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for myself/daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost of medical attention will not be covered or paid by Valley City State University. I authorize release of the information contained in this document to the VCSU School Nurse, Athletic Director, or Certified Athletic Trainer. Continued permission is granted to further share my medical records as deemed necessary with attending physicians and associated medical personnel.

**Date:** \_\_\_\_\_ **Athletes signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian:** \_\_\_\_\_