Altavista Combined School
Athletic Training

904 Bedford Ave, Altavista VA 24517
Phone: 434-369-4768 Fax: 434-369-5191

Proof of Insurance and Waiver

*Insurance is required for all athletes to participate in sports at ACS

I, the undersigned guardian of _____ certify that he/she is covered by our family insurance policy and/or school insurance with:

Insurance Company: _____
*Includes Medicaid & School Insurance

Policy and/or Group Number: _____
**Required for family policies and Medicaid

Name of Policy Holder: _____

My signature below indicates that I relieve the school of any responsibility in the event of an accident resulting from athletic participation and have adequate insurance with the company listed above to cover accidents. I understand that in the event of any insurance coverage change, it is my sole responsibility to notify the school of this change, and I cannot hold the school liable for any injury or accident that occurs from my son/daughter's participation in athletics.

Parent/guardian signature: _____ Date: _____

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Permission for Medical Treatment

Permission is hereby granted to the Altavista Combined School Athletic Training Staff to proceed with any medical treatment deemed necessary and appropriate for (name of student): _____. This includes the use of any modalities such as ice, heat, whirlpool, ultrasound (deep heat), electrical muscle stimulation, massage, exercise rehabilitation, taping, wrapping, bracing etc.

In the event I cannot be reached in an emergency, I understand that the decision for emergency medical treatment and/or emergency surgery will be made by the attending physician, EMS, and/or the Athletic Training Staff.

Parent/Guardian Signature: _____ Date: _____

Relation to the above named individual: _____

Emergency contact number(s): Home: _____
Work: _____
Cell: _____
Email: _____

Family Doctor: _____
Phone number of doctor: _____