KOLORADO
lituanistinė mokykla

(**For Uninsured Students**, under 19 years of age)

To: Colorado Lithuanian School

4189 W 97th Ct., Westminster, CO 80031

E-mail: KoloradoLTmokykla@gmail.com

MEDICAL RELEASE of

_____

Print Name of Child

Born on _____, _____

Month, Day Year

Home address) _____

_____

_____

I (we) acknowledge that the above-named individual is attending Colorado Lithuanian School in Westminster, CO without health insurance.

In case of sudden illness to the above-named individual in any Colorado Lithuanian School (hereinafter referred to as the School) activity whatsoever, I (we), as parent or parents, guardian or guardians authorize the senior representative of the School present to give any and all emergency medical treatment necessary.

Should it be impossible to reach me (us) in an emergency, I (we) hereby grant authority to the senior representative of the School present to select and retain a physician; and I (we) authorize that physician to hospitalize, secure proper treatment, and to order injections, anesthesia, or surgery for the above-named individual.

Furthermore, I (we) agree to indemnify the School, its administration, and their successors and assigns and save them harmless from any and all debts, liabilities and expenses incurred as a result of any medical treatment given the above-named individual. I (we) understand that any resulting debts, liabilities and expenses are exclusively our responsibility.

Signed on this _____ day of _____, _____

Parent or Guardian _____ Signature _____

Parent or Guardian _____ Signature _____

Address _____

_____

_____