

LOS RIOS COMMUNITY COLLEGE DISTRICT
Medical Treatment Release Form

I, the undersigned, have been offered medical assistance by a member of _____
College police department and/or health center as a result of illness or injury.

I acknowledge that I have been informed of the risks involved (including injury or death) and have chosen to decline treatment, transportation to a medical facility or recommendation for treatment. I hereby release _____ College, its employees, volunteers, and the Los Rios Community College District from all liabilities for injuries (including death) and/or damages and/or any liability, civil or criminal, which may result from lack of such medical care.

By my signature below, I further acknowledge that I fully understand the terms of this document, and am signing this document voluntarily and freely.

Date/Time

(Name) Last

First

Signature

Address

City

Zip

Telephone Number

Location of Incident

College Employee's Name

Signature

Telephone

Witness Name

Signature

Telephone