MEDICAL AUTHORIZATION FORM

If a student is under 18 year old, a parent or guardian must complete this form.

Student’s Name: ______________________________________________________________________

I hereby authorize qualified medical diagnosis and treatment of illness or injury to this applicant, and authorize release of medical information for medical treatment and insurance purposes. I understand that I am responsible for medical expenses outside the limits of any applicable medical insurance.

Parent/Guardian Signature: ______________________________________________________________________

Date: ______________________________________________________________________

Please email or fax your signed form to the school you are applying to:

SPRING INTERNATIONAL LANGUAGE CENTER
LITTLETON CENTER
2575 West Church Avenue
Littleton, Colorado 80120

Phone: +1 303.797.0100   Fax: +1 303.797.0127   E-mail: info@spring.edu   Website: www.spring.edu

SPRING INTERNATIONAL LANGUAGE CENTER
DENVER CENTER
1600 Champa Street, Suite 400
Denver, Colorado 80202

Phone: +1 303.534.1616   Fax: +1 303.534.2424   E-mail: denver@spring.edu

SPRING INTERNATIONAL LANGUAGE CENTER
UNIVERSITY OF ARKANSAS
1 University of Arkansas
Fayetteville, Arkansas 72701

Phone: +1 479.575.7600   Fax: +1 479.575.7673   E-mail: silc@uark.edu

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