Consent to Emergency Treatment
Dallas County Community College District ("DCCCD")
Minor Student Under Age 18

_______________________________ ______________ ______________
Print Student Name (Last, First, Middle) **Date of Birth** **Program**

DCCCD on behalf of___________________________College is an educational institution in which
Campus Location
the student named above is enrolled.

Voluntary Student Health Information		
Allergies to Medicine(s)	**Allergies to Food / Other**	**List Medicines this student takes every day.**
1).	1).	1).
2).	2).	2).
3).	3).	3).
List Health Problems or Concerns you believe the College should be aware of in Case of Emergency:		
A.		
B.		
C.		

The College has written authorization to consent to emergency medical treatment from a person having the right to consent as follows:

I,___________________________________ , ___________________________________
Print Name (Parent / Legal-Guardian) (Relationship to the Student)

grant College permission to authorize emergency medical treatment for the above named student.

Parent / Legal Guardian's Contact Information			
Print Name		**Print Name**	
Cell #		**Cell #**	
Work #		**Work #**	
Home #		**Home #**	
Pager #		**Pager #**	

In the event a Parent or Legal Guardian cannot be reached, please contact:		
Emergency Contact #1 (Print Name below)	**Relationship to student:**	**Contact Numbers**
		Work/Home/Cell #:
Emergency Contact #2 (Print Name below)	**Relationship to student:**	Work/Home/Cell #:

The undersigned is responsible for all medical costs associated with this authorization.

_______________________________ _______________________________
Signature of Parent or Legal Guardian **Date**

This authorization is effective until ____________________
Date