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

Print Name (Last, First, Middle)	Date of Birth	Program

DCCCD on behalf of _____ College (College) is an educational institution in which _____, a student, is enrolled and College has received written authorization to consent to emergency medical treatment from a person having the right to consent as follows:

I, _____, the _____ [relationship to student] grant College permission to authorize emergency medical treatment for the above named student. This authorization is effective until _____ [date]. The undersigned is responsible for all medical costs associated with this authorization.

Signature of Parent or legal guardian	Date

Work No.	Home No.	Cell Phone	Pager No.

In the event that parent or legal guardian cannot be reached, please contact

Emergency Contact #1:

Name	Relationship	Work/Home No.

Emergency Contact #2:

Name	Relationship	Work/Home No.

Voluntary Health Information

Allergies: _____

_____

Current Medications & Dosages: _____

_____

List Health Problems You Believe the College Should Be Aware of In Case of Emergency:

_____