DCCCD Minor Student
Under Age 18

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

Consent to Emergency Treatment

Dallas County Community College District on behalf of ____________________ 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 to the above named student in the event that the College is unable to contact me. 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:

____