Consent to Emergency Medical Treatment
Dallas County Community College District (DCCCD)
Minor Student

This form grants authority to the College or its employees to consent to and arrange for medical treatment for a minor (under age 18) enrolled in a College of DCCCD in the event of an emergency, where the minor is not accompanied by a parent or legal guardian and it may not be feasible or practical to contact a parent or legal guardian to obtain consent.

Name of Minor: _____

Date of Birth: _____ Student ID#: _____

Campus location: _____

Program name: _____

Home Address (Street, City, State, Zip Code): _____

_____

Parent/Guardian Name: _____ Relation to Minor: _____

Phone Number: _____

I, _____, the parent/legal guardian of _____ (minor), give my consent for the College to authorize emergency medical treatment for the above-named minor by a licensed health care professional, should the need arise, while he/she is enrolled in and attending a College of the DCCCD. This consent will be in effect from this date until minor is 18 years of age, unless cancelled earlier by me in writing.

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

_____ _____

Signature of Parent/Legal Guardian Date

In the event a Parent or Legal Guardian cannot be reached, please contact:

Emergency Contact (Name, Phone): _____ Relation to Minor: _____

Emergency Contact (Name, Phone): _____ Relation to Minor: _____

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Pertinent Medical History: _____

_____

If necessary, please attach a separate page listing any additional allergies, medications or medical history.

OFFICE USE ONLY

NOTES: