# 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**

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NOTES: