Dallas County Community College District 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 and Dosages: _____

_____

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

_____

Tex. Family Code § 3 2.001 May , 2002

Brookhaven College
DALLAS COUNTY COMMUNITY COLLEGE DISTRICT

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