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

_____ _____ **_Dual Credit**

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

DCCCD on behalf of Richland 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 the student's 18th birthday, which is _____ [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:

_____