Tarrant County College District

Health Services Form

Consent to Emergency Treatment for Minor Student

Name: _____ DOB: _____ Date: _____

Campus: _____ Student ID: _____

Parent/guardian: _____ Home #: _____
Cell #: _____ Work #: _____
Parent/guardian: _____ Home #: _____
Cell #: _____ Work #: _____

In case of an emergency and parents cannot be reached, who should be contacted?

1. Name : _____ Relationship to Student: _____
   Home #: _____ Cell #: Work #: _____

2. Name : _____ Relationship to Student: _____
   Home #: _____ Cell #: Work #: _____

Physician: _____ Phone #: _____
Preferred Hospital: _____ Phone #: _____

Consent to Emergency Treatment

Tarrant County College District is an educational institution in which _____, a student, at the 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 Tarrant County 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 shall remain in effect until revoked by me in writing and delivered to TCCD.

The undersigned is responsible for all medical costs associated with this authorization. Furthermore, no liability is attached to either TCCD or any of its members and staff for such action.

_____ _____
Signature of Parent or Legal Guardian Date

Minor Student Health Information

Allergic to (meds, food, insects, etc.): Type of reaction (rash, difficulty breathing, etc.):

_____

Current medical diagnoses or disabilities:

_____

Past injuries/illnesses/hospitalizations/surgeries:

_____

List any medications currently taking below.

Medications	Strength	Dose	Time Given:

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Medication Administration Request Form

Student: _____ *Date of Birth:* _____

School Name: _____ *Grade:* _____

Physician/Licensed Prescriber to complete:

Medication Allergies: _____

MEDICATION(S)	*STRENGTH*	*DOSAGE*	*ROUTE*	*TIME(S)*	*COMMENTS*

Physician/Licensed Prescriber's Signature: _____ *Date:* _____

Physician/Licensed Prescriber's Printed Name: _____

Phone: _____ *Fax:* _____

Parent/Guardian to complete:

I hereby represent and attest that I am the ***parent or legal guardian*** *of the above-named student. I hereby request that the medication(s) specified above be administered to the above named student beginning on the following date:* _____ *and ending on the following date:* _____.

As long as a physician authorizes a refill of any prescription set forth above, this authorization shall apply to any such refills. On behalf of the above named student, myself, and our personal representatives, family members, heirs, assigns, and successors, I also agree and do hereby waive and release all claims for loss, damage, or injury against the Fort Worth Independent School District and any teacher, employee, volunteer, agent or other person arising directly or indirectly out of any act or omission relating to the receipt, administration, or execution of this request. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

Parent/Legal Guardian's Printed Name: _____ *Date:* _____

Parent/Legal Guardian's Signature: _____

Telephone: Home _____ *Cell* _____ *Work* _____

CONFIDENTIAL PROTECTED HEALTH INFORMATION: *This document contains or requests "protected health information" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal and Texas law and District policy prohibit, and require utilization of appropriate safeguards against, wrongful use, access or disclosure of protected health information, other than as allowed by applicable Federal and state law and District policy. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal and/or State law, discipline by the District, or both.*

Form 738 R 7/14HS

Tarrant County College District

Health History/Patient Visit/Treatment Record
Tarrant County College Health Center

Please Print

Circle one
Staff
Student
FTIC
ECHS
Visitor
Child

Time: Date:

Name:
Last name First name Colleague ID Number

Mailing Address:
Street City Zip

Home phone: Business/cell

Birthdate: Gender: Male / Female

In case of emergency notify:

Name:
Last name First name Relationship

Home phone: Business/cell

Physician's name: Phone:

The following health history information is voluntary and confidential. No information will be released without your written consent unless required to do so by law. Health information will help the Health Center staff serve you better in both routine and emergency situations.

Medications you are currently on: ***OTC and RX***

Check any of the following conditions you have or have ever had

Arthritis	_____	Hemophilia	_____
Asthma	_____	Hepatitis	_____
Cancer	_____	High blood pressure	_____
Diabetes	_____	Kidney disease	_____
Fainting/dizziness	_____	Physical disability	_____
Frequent Depression	_____	Seizures/convulsions	_____
Frequent worry/nervousness	_____	Stomach disorders	_____
Heart condition	_____	Other health problems	_____

Allergies _____ If yes, list & include food, medications, environmental pollutants:

Do you use tobacco products? Yes/No If yes, have you thought about quitting? Yes / No

In the event of an emergency illness, accident, or injury, I hereby grant permission for the college staff to give emergency first aid and/or call an ambulance to have me transported to a hospital at my expense.

Signature Date

Health History/Patient Visit/Treatment Record
South Campus Health Center
