



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?

- Name : _____ Relationship to Student: _____
Home #: _____ Cell #: _____ Work #: _____
- 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:
_____	_____	_____	_____
_____	_____	_____	_____