



FERPA RELEASE/PROXY AUTHORIZATION – The Colleges of DCCCD

The **Family Educational Rights and Privacy Act of 1974**, commonly referred to as **FERPA**, provides that all non-directory record information pertaining to a student (currently or formerly enrolled) that is maintained by the College must be available for inspection, review, and amendment by the student. Release and/or disclosure to third parties requires written authorization from the student in most cases. The Colleges of the Dallas County Community College District require this authorization to be submitted by the student to the College, accompanied by the student's valid photo ID. In addition, the student must specify the person(s) to whom authorization is being given, the relationship of the person(s) to the student, designated documents if not all-access, and the duration of the authorization. Only natural persons may be named as parties to this authorization; corporate entities may not be listed as authorized parties. Authorization submitted to any of the DCCCD Colleges will be considered authorization for the Colleges of DCCCD: Brookhaven College, Cedar Valley College, El Centro College, Eastfield College, Mountain View College, North Lake College, and Richland College.

>>> THIS FORM WILL NOT BE ACCEPTED IF STUDENT PHOTO ID IS NOT PRESENTED AT THE TIME OF SUBMISSION <<<

STUDENT INFORMATION

Student Name (please print): _____

	Last Name	First Name	Middle Initial
Student DCCCD ID Number: _____		Optional – Student date of birth: _____	
<i>(Do NOT list SSN. Copy of student's photo ID is required)</i>		<i>(if ID number is unknown)</i>	

I hereby grant approval to any and all of the Colleges of the DCCCD for the release of my student record information to the person(s) named below.

Student Signature: _____ Beginning Date: _____ End Date: _____
 (Presumed one year if left blank)

AUTHORIZED RECORD ACCESS (Check all that apply. If no selection is made below, access to "ALL" records will be presumed.)

- ALL** – Includes all student record information on file and permits authorized person(s) to act as a proxy for the student
- OFFICIAL TRANSCRIPT(S)** – Permits authorized person(s) to order official transcripts of the Colleges of DCCCD to be sent to a third party individual, institution, company, or other organization
- DIPLOMA/CERTIFICATE** – Permits authorized person(s) to obtain any diploma(s) and/or certificate(s) earned by student
- ENROLLMENT VERIFICATION** – Permits authorized person(s) to verify student enrollment in any/all of the Colleges of DCCCD
- REGISTRATION** – Permits authorized person(s) to add or drop classes on behalf of student
- OTHER** (Please specify) - _____

AUTHORIZED PERSON(S) (Please print clearly. List each authorized person and relationship to student: **P=Parent, G=Guardian, S=Spouse, O=Other**)

* Note: Authorized person(s) **MUST** present photo ID at time of transaction.

		P	G	S	O
<input type="checkbox"/> Release to _____ Relationship to student (Mark only one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Release to _____ Relationship to student (Mark only one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Release to _____ Relationship to student (Mark only one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Release to _____ Relationship to student (Mark only one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Release to _____ Relationship to student (Mark only one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE USE ONLY

STUDENT PHOTO ID IS REQUIRED WITH FORM Verified by _____ Date _____
COLLEGE RECEIVING SUBMITTED FORM _____

**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

NOTES: