Illinois Eastern Community Colleges

# Mental Health Contact Authorization

State law provides you the opportunity to designate an adult whom you would like to be contacted in the event you experience a mental health emergency that puts you and/or others at risk for serious injury or death. **You are not required to designate a contact;** however, should you choose to designate someone, it can be anyone over the age of 18 (parent, relative, sibling, family friend etc.). **NOTE: Under certain circumstances, as allowed or required by law, IECC officials may contact parents/guardians or others without express written consent.**

Student ID: ______________________________ Date of Birth (MM/DD/YYYY): ________________________

Name (please print): ____________________________________________________________________

(First) (Middle) (Last)

Address: _______________________________________________________________________________

City: ___________________________________________ State: ______________ Zip: ________________

Phone: (______) ______________________________________

Primary College of Attendance (check one): ___ FCC ___ LTC ___ OCC ___ WVC

Please check the action you would like to take (Select only one):

___ I DO NOT wish to designate an individual as a contact.

___ I would like to revoke my authorization currently on file. (You will no longer have a contact on file).

___ I would like to designate my contact as the individual identified below.

___ I would like to change my contact to the individual identified below.

**I give permission for IECC to contact the following person in the event I am evaluated by IECC's Mental Health Specialist and determined to pose a clear danger to myself and/or others. I understand by signing below I am authorizing IECC's Mental Health Specialist to discuss provided and/or observed mental health concerns, behaviors, and information with this Designated Person.**

Designated Person's Name: ________________________________ Relationship: __________________________

Address: ____________________________________________________________________________________

City: ______________________________________________ State: ______________

Phone Number: (_____) ________________________ Email: __________________________________________

________________________________________________ ____________________________

Student Signature Date

**This authorization is in effect as long as you are enrolled at IECC unless revoked or changed, which you may do so at any time by completing another form. Please return completed form to Student Services.**

******************************** FOR OFFICE USE ONLY ******************************

Entered in Banner by: ____________________________________ Date: __________________________

(Emergency Contact added as **Priority 9**)

___ Copy to Mental Health Specialist