

**Family Wellness Center
School of Nursing
The University of Texas at Austin**

CONSENT BY MINOR TO OWN TREATMENT
Patient Information and Consent

The undersigned minor, less than eighteen (18) years of age, hereby consents to medical treatment at the Family Wellness Center (FWC) by FWC providers and/or other appropriate FWC staff.

1. Name of minor patient: _____

2. The undersigned minor has legal power to consent to medical care because the minor (CHECK ONE OR MORE):
 - is on active duty with the armed forces of the United States of America,
 - is 16 years of age or older and resides separate and apart from his/her parents, managing conservator, or guardian (whether with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence), and is managing his/her own financial affairs (regardless of the source of the income).
 - is consenting to diagnosis and treatment of any infectious, contagious or communicable disease which is reportable to the Texas Department of Health.
 - is unmarried and pregnant and is consenting to medical treatment related to the pregnancy.
 - is consenting to examination and treatment for drug addiction, drug dependency, or any other condition directly related to drug use.
 - is consenting to counseling for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse.
 - is an emancipated minor.

3. I certify that I have read and fully understand the foregoing consent, that the facts indicated under 2 above are true, and that all blanks or statements requiring insertion or completion were filled in before I signed.

SIGNATURE OF PATIENT

SIGNATURE OF WITNESS

DATE

PLEASE READ AND SIGN BELOW:

I have received a copy of the Family Wellness Center *Notice of Privacy Practices* as required by HIPAA Privacy Rules.

SIGNATURE

DATE

NAME (PRINT FIRST AND LAST NAME)

**CONSENT FOR TREATMENT OF
A MINOR WHO DOES NOT HAVE LEGAL POWER TO CONSENT**
Information and Consent

Name of Minor: _____

Date of Birth: _____

Address (Street, City, State, Zip Code): _____

Parent/Guardian Phone Number: _____
HOME WORK

I, the undersigned, as the parent or legal guardian of _____
(a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any an all claims and causes of action that my arise, grow out of, or be incident to such diagnosis, treatment, or surgery in so far as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

PRINT NAME

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

CONDITION WAS URGENT. Parental/guardian consent for treatment was obtained by telephone from:

NAME OF PARENT/LEGAL GUARDIAN

TIME AND DATE

by _____
SIGNATURE OF NURSE OBTAINING CONSENT