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

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: _____________________________________________

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 is 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 and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar 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 ________________________________