CONSENT TO MEDICAL TREATMENT OF A MINOR

The undersigned hereby consents on behalf of the below named minor less that eighteen ( ) to the medical diagnosis or treatment described below to be performed by Dr. _____
And/or by any person(s) he may designate as assistants.

1. Name of minor _____

   Name of Parents/Managing Conservator/Guardian _____

2. Relationship of minor to the undersigned:
   _____ Parent
   _____ Managing Conservator
   _____ Possessory Conservator
   _____Guardian of the person
   _____ Grandparent
   _____ Brother or sister, eighteen (18) years or older
   _____ Aunt or Uncle, eighteen (18) years or older
   _____ Judge of the Court having jurisdiction of the child
   _____ Person over , responsible for the care and treatment of a minor under the Jurisdiction of a juvenile court.
   _____ Texas Youth Commission
   _____ Educational institution in which the minor is enrolled that has received written Authorization to consent (from a person authorized by law to consent to medical care For the minor, written authorization must be attached.)
   _____ A person 18 years or older who has care and control of the minor and has written Authorization to consent to medical care for the minor (from a person authorized to give Such consent)
   _____ The person having power to consent cannot be contacted and actual notice to the Contrary has not been given by that person.

3. Grounds upon which minor has capacity to consent to his own medical treatment:
   _____ Active armed services
   _____ Sixteen (16) years old and living independently
   _____ for reportable communicable disease
   _____Unmarried and Pregnant
   _____ for blood donation
   _____ For chemical dependency

4. Statement of nature of the medical treatment, including any emergency involving an immediate danger to the health and safety of the child and foreseeable risks:
   _____
   _____
   _____

5. I have been informed of the nature and purposes of this diagnosis or treatment, of possible alternatives and of the risks and dangers of complications. I authorize any additional or different diagnosis or treatment, which the physician may deem necessary.

6. Date on which diagnosis or treatment is to begin: _____
7. I certify that I have read and fully understand the foregoing consent, that the explanations therein referred to were made and that all blanks were filled in before I signed.

SIGNED this _____ day of, 20_____.

_____ Witness _____

_____ Witness _____