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3536 Holly Road
Corpus Christi, Texas 78415
361 855-9107 (ph) 361 855-6822 fax

4410 Dillon Lane, Ste 1
Corpus Christi, Texas 78415
361 857-0101 (ph) 361 855-0003 fax

CONSENT FOR MEDICAL TREATMENT OF MINOR

Name of Minor___________________________________ Date of Birth________________ Age_____

Women's and Men's Health Services is concerned with the health of teens in the Coastal Bend area. Women's and Men's Health Services provides comprehensive health care to teens at little or no cost. Services may include physical examinations, immunizations, primary health care, dispensing of common over the counter medications and prescription medications, basic laboratory testing, testing for pregnancy, STI and HIV, birth control education and supplies, nutrition counseling, and health education.

Please read carefully and fill out the consent form below for the minor patient to receive the above health services from Women's and Men's Health Services. If you have any questions, you may contact the medical staff at the numbers listed above.

I give my consent for the minor named above to receive confidential medical treatment at Women's and Men's Health Services clinics. I give my permission for necessary medical examinations, laboratory tests, procedures and treatments in the evaluation and management of the minor's health care. I waive my right to review and sign a consent form for the birth control method the minor may choose. I will inform clinic staff about all known allergies, any reactions caused by medications or drugs in the past, any chronic illnesses and any medications the minor is taking now. This consent begins on the date below and remains in effect unless revoked in writing.

ALLERGIES/REACTIONS (IF ANY)____

CURRENT MEDICATIONS_____________________ CHRONIC MEDICAL ILLNESSES______________

I have read and completed this consent form for the minor listed above.

___________________________________ ______________________________ ____________

Printed Name of Person Giving Consent **Signature of Person Giving Consent** **Date**

I am the (check one) ___parent ___managing conservator ___guardian of the above named minor

The parent/managing conservator/guardian for the above minor cannot be contacted and has not given notice to the contrary. As per Texas Family code Chapter 32.001 I may consent for medical treatment of the above named minor. (I am the (check one):

___grand parent ___adult brother/sister ___adult aunt/uncle

___adult with care/control/possession with written authorization to consent from the person having the right to consent

___adult responsible for minor under juvenile court order ___TYC staff

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Complete this section only if you are an emancipated minor

CONSENT BY EMANCIPATED MINOR

_____ I am an emancipated minor

_____ I am age 16 or older, living separate and apart from my parents/managing conservator/guardian, and manage my own financial affairs.

I declare under penalty of perjury that the above information is true and correct.

___________________________________ ______________________________

Signature of Minor Date