BAYLOR COLLEGE OF MEDICINE TEEN HEALTH CLINIC
MINOR PATIENT CONSENT FORM

Baylor College of Medicine

Baylor College of Medicine Teen Health Clinic ("Clinic") is concerned with the health of teenagers in the Houston area and provides comprehensive health care services to teens at little or no cost. Services are provided by licensed and board-certified health professionals experienced in providing services to adolescents. Comprehensive medical services offered include:

- Physical Examinations
- Sports physicals/sports injuries
- Common acute and chronic health problems
- Laboratory Testing
- Immunizations
- Referrals for medical problems including dental, mental, nutritional, and social services
- Confidential sexually transmitted infection (STI) and HIV testing, STI treatment, and pregnancy testing
- Pregnancy prevention and education, including over-the-counter and prescription birth control methods
- Common menstrual and gynecological problems
- Dispensing of common over-the-counter and prescription medications

**Services vary by location, and some services are not available at all locations.*

The Clinic provides care in accordance with state and federal law. There are some times when the law allows a minor patient to consent to his/her own treatment, such as pregnancy testing and confidential STI/HIV testing and treatment. The Clinic staff provides confidential care as allowed by law while at the same time encourages parental involvement in the care and treatment of its minor patients. Please read carefully and fill out the consent form below for the minor patient to receive health services.

CONSENT FOR TREATMENT AND PREVENTATIVE HEALTH SERVICES OF MINOR

Name of Minor: _____ **Date of Birth:** _____ **Age:** _____

☐ **yes** ☐ **no**	**I give my consent for the minor patient to receive medical treatment, which includes necessary medical examinations, laboratory tests, procedures and treatments in the evaluation and management of the minor's health care. I will inform the clinic staff about all known allergies, any reactions caused by medications or drugs in the past, any chronic illnesses and any medications the minor patient is taking now.**
☐ **yes** ☐ **no**	**I give my consent for the minor patient to choose a method of prescription birth control.**

ANY ALLERGIES/REACTIONS _____

CURRENT MEDICATIONS_____

ADDITIONAL MEDICAL INFORMATION _____

I understand that if I have any questions I should contact the medical staff at the clinic before signing this consent form. By signing, I agree that I have read and understand this consent form. This consent begins on the date below and remains in effect until the patient's 18th birthday unless withdrawn in writing.

_____ _____ _____

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

Relationship to Patient (check one): ☐ Parent ☐ Legal Guardian ☐ Managing Conservator ☐ Other (below)

The parent/managing conservator/guardian for the above named minor is: _____. He/she cannot be contacted and has not given notice to the contrary; therefore, according to the Texas Family Code, Chapter 32.001, I am consenting for medical treatment of the above named minor because I am a(n):

☐ Grandparent	☐ Educational institution in which the patient is enrolled and with written authorization to consent from the person having the right to consent
☐ Adult brother/sister	☐ Adult responsible for a minor under court order
☐ Adult aunt/uncle	☐ Peace officer who has lawfully taken custody of the minor
☐ Adult with care/control/possession and written authorization to consent from the person having the right to consent	