PRECISION
ORTHOPEDICS & SPORTS MEDICINE

CONSENT TO MEDICAL TREATMENT OF A MINOR

The undersigned hereby consents on behalf of the below named minor less than eighteen (18) years of age 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 (please print) _____

   Name of Parents/Managing Conservator/Guardian (please print) _____

2. Relationship of the undersigned to the minor:
   _____ 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 18 years of age, 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 from a person authorized by law to give such consent to medical care (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 (written authorization must be attached).
   _____ 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 the minor has capacity to consent to his/her 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 authorize for any different diagnosis or additional treatment, which the physician may deem necessary, for this minor.

6. Date on which the diagnosis or treatment is to begin: _____

7. I certify that I have read and fully understand the foregoing consent, and that the explanations therein referred to were made and that all blanks were filled in before I signed.

Patient: _____ DOB: _____

Signature: _____ Date: _____