THE UNIVERSITY OF TEXAS AT DALLAS
STUDENT HEALTH CENTER

CONSENT BY MINOR TO OWN TREATMENT

Patient Information and Consent

Patient Name _____ D.O.B _____ Gender _____

Address _____ ID # _____

The undersigned minor, less than eighteen (18) years of age, hereby consents to medical treatment at The University of Texas at Dallas (UTD) Student Health Center (SHC), by SHC providers and /or other appropriate SHC staff.

1. Name of the 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.

1. AUTHORIZATION FOR EXAMINATION AND TREATMENT:

The undersigned has been informed that examination procedures, vaccines and/or treatment considered necessary for the patient named on this record will be performed by the Nurse Practitioner, Consulting Physician, or other employees of the UTD Student Health Service (AKA Student Health Center). Authorization is hereby given for such treatments and procedures and the administration of such local anesthetics, medications, or other treatment deemed necessary. I certify that I have read the above authorization, and understand the same and also certify that no guarantee or assurance has been made as to the results that may be obtained. The Nurse Practitioners, Consulting Physician, appropriate staff and The University of Texas at Dallas and it's 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.

2. RELEASE OF INFORMATION:

I hereby consent to the release of my medical information to authorized UTD Student Health Service staff, Counseling Center staff, and consulting physicians, including those seen in the Health Center and/or those seen on a referral basis from the Health Center, also including hospital Emergency Rooms and medical personnel with ambulance services.

3. ACKNOWLEDGEMENT OF REFERRAL SERVICES:

I hereby acknowledge that medical care and/or treatment deemed necessary for the undersigned may involve referral to specialty physicians, Emergency Rooms, X-ray facilities, or other providers outside the UTD Health Center, and that any and all expenses for referral services are the responsibility of the patient.

4. CONSENT TO PERMIT TESTING AFTER AN OCCURRENCE OF A BLOOD OR BODY FLUID EXCHANGE:

In the course of care and treatment within the UTD Health Center, health care workers may be accidentally exposed to a patient's blood or body fluids (through needle sticks, blood splatters, etc.). Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposures of this type. When a health care worker is exposed to a patient's blood or body fluid, the patient must be tested for HIV antibody and other communicable diseases in order to determine whether an actual exposure has occurred. This information is necessary so that the health care worker can receive appropriate counseling and medical treatment. I understand and agree, that in the event a health care worker is exposed to my blood or body fluids, my blood will be tested, at no cost to me, in a confidential manner, for HIV antibody, and other communicable diseases. The results of these tests will not prejudice my patient relationship in the Student Health Center.

5. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES of the UTD Student Health Service. This information describes how my medical information may be used and disclosed and how I may have access to the information. HIPAA Privacy Rules require that we furnish you with the notice.

6. 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 DATE

_____
SIGNATURE OF WITNESS DATE

11/2003
5/2009