AUSTIN SPORTS MEDICINE
Central Park Medical Office Building
900 W. 38th Street • Suite 300
Austin, Texas 78705-1130

(tel) 512.450.1300
(fax) 512.450.1339
www.austinsportsmed.com

Carey Windler, M.D.
Kelly Cunningham, M.D.
Doug Elenz, M.D.
Nathan Breazeale, M.D.
BOARD CERTIFIED, ORTHOPAEDIC SURGERY
FELLOWSHIP TRAINED, SPORTS MEDICINE

Jim Fernandez, M.D.
BOARD CERTIFIED, PHYSICAL MEDICINE AND REHABILITATION
BOARD CERTIFIED, ELECTRODIAGNOTIC MEDICINE

CONSENT TO TREAT A MINOR

This consent has been prepared according to guidelines presented by the Texas Family Code (Section 35.01). Please complete all information.

Minor's Full Name: _____ **Date of Birth:** _____

Mother and Father's name or name of guardian(s):

_____

Name of person giving consent: _____

Relationship to the minor: _____

Describe the medical treatment for which consent is to be given:

_____

_____

Date treatment is to begin: _____

The following person's may consent to a minor's medical treatment when the person having the power to consent cannot be contacted and when the absent person has not indicated a refusal to consent. Please indicate the appropriate situation as to who will be signing the consent.

_____ **Grandparent**

_____ **Adult aunt or uncle**

_____ Adult Brother / Sister

_____ An educational institution in which the minor is enrolled, if the person who has the power to consent has **given the institution prior written authorization to do so**

_____ **Any adult who has care and control of the minor, if the child's parent or guardian has given prior authority to consent**

_____ Any court having jurisdiction of the child

_____ _____
Signature of Consenting Adult **Date**

PHONE CONSENT

When consent to treat the above minor was not possible, consent to treat was provided over the telephone by _____, **whose relationship to the minor is as follows:** _____.

_____ _____ _____
Signature of Office Staff Date Title of Office Staff