AUSTIN SPORTS MEDICINE

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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