I, [name of minor] , am currently [number of years] years of age. My date of birth is .

My father’s name (if known) is . My mother’s name (if known) is

. IF APPLICABLE: The name of my managing conservator or legal guardian is .

I, [name of minor] , give consent for my own medical treatment. The nature of the medical treatment to be given to me is as follows:

* Medical:
* Dental:
* Psychological:
* Surgical:

The treatment is to begin on [start date for treatment]:

I have legal authority to consent to the treatment described above under Tex. Fam. Code § 32.003 because I (check one or more):

* am on active duty with the armed forces of the United States of America
* am 16 years of age or older and reside separate and apart from my parents, managing conservator, or guardian, and manage my own financial affairs
* consent to the diagnosis and treatment of an infectious, contagious, or communicable disease as required by law or rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of State Health Services and including all diseases within the scope of Tex. Health & Safety Code Ann.§ 81.041
* am unmarried and pregnant and consent to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy
* am consenting to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition related to drug or chemical use
* am unmarried, am the parent of a child, have actual custody of my child, and consents to medical, dental, psychological, or surgical treatment for the child

I certify that I have read and fully understand the above consent; that the facts indicated above are true; and that all blanks or statements requiring insertion or completion were filled in before I signed.

|  |  |  |
| --- | --- | --- |
| Minor Name (Printed) | Minor Signature | Date of Consent |

I, [name of minor]

# Jane Doe

, am currently [number of years] 16

years of

age. My date of birth is \_01/01/2003 .

My father’s name (if known) is

# Donna Doe

David Doe . My mother’s name (if known) is

. IF APPLICABLE: The name of my managing conservator or

legal guardian is \_none .

I, [name of minor]

# Jane \_Doe

, give consent for my own medical treatment.

The nature of the medical treatment to be given to me is as follows:

* Medical:

# physical and x-ray

* Psychological:
* Dental:  Surgical:

The treatment is to begin on [start date for treatment]:

# 12/15/2019

I have legal authority to consent to the treatment described above under Tex. Fam. Code § 32.003 because I (check one or more):

* am on active duty with the armed forces of the United States of America
* am 16 years of age or older and reside separate and apart from my parents, managing conservator, or guardian, and manage my own financial affairs
* consent to the diagnosis and treatment of an infectious, contagious, or communicable disease as required by law or rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of State Health Services and including all diseases within the scope of Tex. Health & Safety Code Ann.§ 81.041
* am unmarried and pregnant and consent to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy
* am consenting to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition related to drug or chemical use
* am unmarried, am the parent of a child, have actual custody of my child, and consents to medical, dental, psychological, or surgical treatment for the child

I certify that I have read and fully understand the above consent; that the facts indicated above are true; and that all blanks or statements requiring insertion or completion were filled in before I signed.

Minor Name (Printed) Minor Signature Date of Consent