MISSION EAST DALLAS
FAMILY HEALTH CLINIC

Consent for Minors Policy

Appendix A

Authorization for Consent to Treat a Minor

Mission East Dallas (MED) requires information about any individuals that you may allow to provide consent for your child, in the event that you are not able to be present for their appointment. In non-emergency situations, it is necessary to obtain your consent prior to providing treatment to your child. Providing MED with this valuable information may prevent delay of treatment for your child.

Please also be sure to complete registration forms with your correct contact information, so that we may reach you with any questions while your child is here for care.

I ,_________________________________(print full name) ________________________(state your relationship to the child), hereby authorize the following individuals to provide consent for my child in my absence:

Name of the Individual:___________________________________ DOB:__________________
Relationship to the Child: _________________________________

Name of the Individual:___________________________________ DOB:__________________
Relationship to the Child: _________________________________

Name of the Individual:___________________________________ DOB:__________________
Relationship to the Child: _________________________________

Please specify the type of care that you authorize these individuals to consent for:

- ○ Medical evaluation and treatment (including immunizations, blood draws or administered testing in the office)
- ○ Dental evaluation and treatment
- ○ Behavioral Health (evaluations or counseling)
- ○ Other: (please specify) ____

Signature Parent/ Guardian____Date___________________

Patient Information
Child's Name____ **Date of Birth**__________________

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Appendix B

Minor Consent Form

Mission East Dallas allows a person under the age of 18 to consent for his/her own treatment, in accordance with the Texas Health and Safety Code. We require that you attest to your capacity to consent for your own treatment by signing the statement below and checking the criteria that qualifies you to do so:

- ○ I am on active duty with the armed forces
- ○ I am 16 years of age or older and reside separately/apart from my parents and manage my own financial affairs
- ○ I am consenting to the diagnosis and treatment of an infectious, contagious or communicable disease that is required to be reported to the health department (sexually transmitted infections, tuberculosis)
- ○ I am unmarried and pregnant and consenting to treatment related to my pregnancy
- ○ I am consenting to an examination and/or treatment for drug and chemical dependency or addiction
- ○ I am consenting to counseling by a physician, psychologist, counselor or social worker for sexual, physical or emotional abuse, suicide prevention or chemical addiction or dependency
- ○ I am an unemancipated minor, but I am a parent with actual custody of my biological child

I ,____(print full name) _______________(date of birth), hereby swear that the above information is true and correct, which allows me to consent to my own care. If I qualify based on criteria for a specific medical or behavioral health condition, I understand that the health care provider is only going to evaluate and treat that condition.