BAYLOR COLLEGE OF MEDICINE TEEN HEALTH CLINIC
PATIENT CONSENT FORM

Baylor College of Medicine Teen Health Clinic ("Clinic") is concerned with the health of teenagers in the Houston area and provides comprehensive health care services to teens at little or no cost. Services are provided by licensed and board-certified health professionals experienced in providing services to adolescents. Comprehensive medical, mental health and social services offered include:

- Physical Examinations
- Sports physicals/sports injuries
- Common acute and chronic health problems
- Laboratory Testing
- Referrals for medical problems including dental, mental, nutritional, and social services
- Dispensing of common over-the-counter and prescription medications
- Confidential sexually transmitted infection (STI) and HIV testing, STI treatment, and pregnancy testing
- Pregnancy prevention and education, including over-the-counter and prescription birth control methods
- Common menstrual and gynecological problems
- Immunizations
- Mental health and social services

**Services vary by location, and some services are not available at all locations.*

CONSENT FOR TREATMENT AND PREVENTIVE HEALTH SERVICES

Name of Patient: _____ Date of Birth: _____ Age: _____

By signing below, I agree that:

- **I give my consent to receive confidential medical treatment at the Clinic, which includes necessary medical examinations, laboratory tests, procedures and treatments in the evaluation and management of my health.**
- **I will inform the clinic staff about all known allergies, any reactions caused by medications or drugs in the past, any chronic illnesses and any medications I am taking now.**
- **I understand that the Clinic will notify me of any abnormal test results and that I will return for follow-up care. I also understand that the Clinic is legally required to report positive test results for certain communicable diseases to the health department.**

I have read and understand this consent and have had an opportunity to ask questions. This consent begins on the date below and remains in effect unless revoked in writing.

_____ _____

Patient Signature ***Date***

MINOR CONSENTING TO OWN TREATMENT	
I am consenting for my own treatment because I am (check all that apply):	
☐ on active duty with the armed forces of the United States of America. ☐ legally married. ☐ 16 years old or older, living separate and apart from my parents/managing conservator/guardian, and managing my own financial affairs. ☐ consenting to diagnosis and treatment of any infectious, contagious or communicable disease, including sexually transmitted infection (STI) ☐ covered under Medicaid (family planning services).	☐ unmarried and pregnant and am consenting to medical treatment related to the pregnancy. ☐ consenting to examination and treatment for drug addiction, drug dependency, or any other condition directly related to drug use. ☐ consenting to counseling for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse. ☐ an emancipated minor (provide court order).