MINNEAPOLIS SCHOOL BASED CLINICS program

Minor Consent

A program of the Minneapolis Department of Health & Family Support

Please initial after each statement to show you have read and understand each statement

Statement	Initial
1. I am able to understand facts and information.	
2. I understand what may happen to me as a result of my actions.	
3. I understand that my sexual activity could lead to pregnancy and/or sexually transmitted disease(s).	
4. I understand that not having sex is the only 100% way to avoid pregnancy and/or sexually transmitted disease(s).	
5. I chose to be sexually active.	
6. I request health services to prevent pregnancy and/or sexually transmitted disease(s).	
7. I believe that the treatment I have asked for will benefit me.	
8. I believe that the treatment is necessary for my health and well being.	
9. Involving my parents in this decision would be a problem for me at this time.	
10. I understand all the options presented to me to prevent pregnancy and/or sexually transmitted disease(s).	
11. I have been given an opportunity to discuss my questions and concerns.	
12. I have no unanswered questions or concerns about the choice I have made to prevent pregnancy and/or sexually transmitted disease(s).	
13. The risks and benefits of the treatment have been explained to me.	
14. The risks and benefits of the treatment I have chosen.	
15. I feel I have been given all the information I need to make this decision about my health care.	
16. I have thought about and compared my options and know what the best choice is for me at this time, *(write in your choice)*: _____	

By signing and dating this document I agree that the statements above are true and represent my current situation. The information discussed today included, but was not limited to, the statements above. I request and consent to reproductive health services.

If I have health insurance or MA, I also authorize the clinic to release information regarding my care to insurer for the purpose of billing. I hereby authorize and request payment to and mailing of payment directly to the Minneapolis Department of Health & Family Support for any health care benefits due under term of my insurance policy for services rendered. I understand that all information about my health care is private date and will be treated in accordance with Minnesota Data Privacy Laws and HIPAA.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date