FENWAY HEALTH

# Parent/Guardian Consent for Gender Affirming Care

**DOB: _____ MRN: _____ Last Name: _____**

**Ask your medical provider any questions you have about the medications and expectations of treatment. When you are comfortable and ready to start the medication(s) selected, please sign this consent on the line below.**

By signing this form, you acknowledge that you and your child have received the information you need to make an informed decision and that you understand the information your medical provider has given you. This includes:

- My child's medical provider has talked with me about the effects and possible risks and benefits for my child, including alternative treatments as appropriate or possible.
- I understand the treatment is considered off-label at this time, meaning not approved for this use by the Federal Drug Administration.
- I have been provided with written information about these medication(s) including the known effects and possible risks, both reversible and permanent. I know that there may be unknown effects or other possible risks.
- I have discussed the impact this medication may have on my child's fertility with my child's medical provider, and been counseled on fertility preservation options as desired and applicable.
- All my questions have been answered to my satisfaction.

---

Based on this information I consent to my child, _____, beginning treatment with the medication(s) selected below.
*Name used*

○ Lupron ○ Testosterone ○ Spironolactone ○ Estrogen ○ _____
*other medication*

---

_____
Patient Signature ▲ Date ▲

_____
Patient Name *Name used*

_____
Parent/Guardian Signature Date

_____
Parent/Guardian Name

*If the parent/guardian listed above is the sole parent/guardian for this patient, please write "N/A" on the second parent/guardian line. Documentation of guardianship may be requested from any parent/guardian prior to initiating any gender affirming care in youth.*

_____
Parent/Guardian Signature Date

_____
Parent/Guardian Name

_____
Provider Signature Date

_____
Provider Name