

I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the doctor or other clinic staff about my conditions that might show I should not take the medication(s).

I have had the chance to ask questions about this health condition. The benefits and risks of specific Hansen's Disease drugs have been explained to me. How long these side effects may last and how bad the side effects may be as well as the risks of not taking treatment have also been explained. I understand that no promises can be made about cure or side effects.

Instructions for the use of the drug(s) have been given to me as follows:

Orally  Written

(Check One) I have read the form  or I have had the form read to me  and it has been fully explained to me. All blank lines have been filled in.

Based on the above, I give this informed consent for the treatment as recommended.

### SIGNATURES

#### Section I:

Patient's Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Person Authorized to Consent  
(if not patient) \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Section II:

I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name \_\_\_\_\_

Name of Person giving consent \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

#### Section III:

Name of Counselor \_\_\_\_\_

Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_