

**DISCLOSURE AND CONSENT TO TREATMENT FOR SEXUALLY TRANSMITTED DISEASES
BY ORAL/INJECTABLE MEDICATION**

The information in this consent form is provided so that you can be better informed about the treatment prescribed for you. After you are sure that you understand the information about the treatment recommended for you and if you agree to receive this treatment, you must sign this form to indicate that you understand and consent to the treatment. After signing, the form will be kept in your medical record.

It has been recommended that I receive oral or injectable medications because (check one)

- I have been diagnosed with _____ OR
 I have been exposed to _____ which is a sexually transmitted disease.

I understand that the drug recommended for treatment or preventative care is:

[Nurse: Check Drug(s) Prescribed/Administered]

- Azithromycin (**Zithromax**) 1g (oral) _____ x a day for _____ days
 Azithromycin (**Zithromax**) 2g (oral) _____ x a day for _____ days
 Cefixime (**Suprax**) 400 mg (oral)
 Ceftriaxone (**Rocephin**) 250 mg (injection)
 Doxycycline 100 mg (oral) _____ x a day for _____ days
 Gentamycin 240 mg (injection)
 Penicillin G. Benzathine (**Bicillin**) 2.4 MU (injection) x _____ doses (If I need more than one dose, I will have to return to the clinic as instructed.)
 Other: _____

I understand that there may be risks and hazards if I do not choose to receive treatment for my condition. Further, I understand that the drug which has been prescribed for me may carry certain risks and hazards depending on the type of drug I am prescribed as follows:

- **Zithromax:** Gastrointestinal Problems (stomach or intestine), Genitourinary (bladder or sex organs), Nervous System, Cardiovascular (heart and blood vessels)
- **Rocephin/Suprax:** Gastrointestinal Problems (stomach or intestine), Hypersensitivity Reaction (allergic), Hepatic (liver), Renal (kidneys), Central Nervous System, Severe or Fatal Reactions (shock, swelling, breathing)
- **Gentamycin:** Allergic Reaction (breathing, swelling), Kidney Problems (difficulty passing urine), Balance/Dizziness Problems, Hearing Loss (and ringing in ears), Muscle Problems (weakness, burning, numbness, twitching), Seizures, Confusion, Low Mood, Headache, Vision Problems
- **Doxycycline:** Gastrointestinal Problems (stomach or intestine)
- **Bicillin:** Severe or Fatal Reactions (shock, swelling, breathing)

I understand that I am responsible for any costs related to complications I experience resulting from the administration of this medication. I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the physician or other clinic personnel about all conditions, including allergies, which might indicate that I should not receive this medication.

I have had the opportunity to ask questions about this sexually transmitted disease or exposure, the risks of not accepting treatment, alternative forms of treatment, the benefits and the risks and hazards of the drug prescribed, and the severity and duration of the indicated side effects. These questions have been answered to my satisfaction. I understand that neither the Texas

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| CI Name: | _____ |
| SS#: _____ | _____ |
| ID# _____ | _____ |
| DOB: _____ | _____ |



TX DSHS Public Health Nursing

Department of Health, its employees, nor the State of Texas has warranted or guaranteed the safety or effectiveness of the treatment indicated.

Based upon all the above, I believe that I have received sufficient information to give, and I do give, this informed consent for the administration of the medication prescribed. This form has been explained to me. I have read the form or The form has been read to me. All the blank spaces were filled in before I signed the form.

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: _____

Date: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____

Section III:

Counselor Signature: _____

Date: _____

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| CI Name: _____ |
| SS#: _____ |
| ID#: _____ |
| DOB: _____ |