

**Employee Health and Well-being
Office (713) 745-6900
Fax (713) 745-3352**

Dear Parent or Guardian of _____,

The University of Texas M.D. Anderson Cancer Center (UT MDACC) welcomes the opportunity to work with your child. We will be providing your child with Employee Health and Well-being services which are needed to protect your child as well as the UT MDACC cancer patients and staff. However, since your child is a minor, we need to ask you for informed consent before we can provide these services.

As you are probably aware, there has been a reappearance of tuberculosis (TB) in the U.S. In Houston we have a significant TB problem in the general community. For this reason, MDACC places a TB skin test on **ALL** new employees. If the results are positive, a chest x-ray is obtained.

Since TB could be life threatening to patients, this screening is mandatory. Your child cannot be hired unless you consent to the TB screening. If this screening is negative your child can begin employment.

If however, your child should be found to have a positive TB test, you will be notified in writing. We will send you information on where to take your child for evaluation. Once you provide medical clearance from a health care provider, your child may begin employment.

Employee Health and Well-being welcomes questions at 713-745-6900 or you may choose to accompany your child to Employee Health and Well-being and ask questions in person. Our hours are Monday thru Friday, 7:30 AM – 4:30 PM.

Sincerely,
Employee Health and Well-being

**CONSENT TO DIAGNOSIS AND/OR MEDICAL TREATMENT
IN EMPLOYEE HEALTH AND WELL-BEING**

I hereby authorize the University of Texas M.D. Anderson Cancer Center and the medical staff in Employee Health and Well-being to provide a pre-employment evaluation; (and if indicated) lab testing; X-ray testing; hepatitis B vaccine; tetanus-diphtheria vaccine, to my son/daughter.

I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me as to the results of treatment or examination either in Employee Health and Well-being or the hospital.

I understand that if another health care worker, patient or other individual is accidentally exposed to my son or daughter's blood or body fluids, they may be tested for blood borne diseases like hepatitis and HIV (the AIDS virus). These results may be released to the affected health care worker and to his/her physician, in accordance with the provisions of the Texas Communicable Disease Prevention and Control Act.

This form has been fully explained to me, and I certify by my signature below that I understand its contents.

Signature of Patient

Witness

Date

Signature of Parent of Guardian

Relationship to Patient