THE UNIVERSITY OF TENNESSEE KNOXVILLE
STUDENT HEALTH CENTER

CONSENT TO A CHAPERONE FOR A MEDICAL APPOINTMENT, EXAM INVOLVING DISROBING, OR SENSITIVE EXAM

Name: _____ **Date:** _____

Student ID: _____ **Time:** _____

My initials and signature below indicate that I hereby consent to (or refuse to permit) _____
(Print Provider's Name)

to perform the following examination(s) and/or procedure(s) in the presence of _____ who is serving as a chaperone:
(Print Chaperone's Name)

_____ **Medical Appointment**
(Patient Initials)

_____ Examination Involving Disrobing
(Patient Initials)
Examination wherein the patient must be completely or partially disrobed, irrespective of the body region being examined/treated. Disrobing is the removal of clothing that may expose the genitalia, breasts, and the perianal region, rectum, and/or buttocks.

_____ Sensitive Examination/Procedure
(Patient Initials)
Examination/procedure involving the:

_____ Genitalia.
(Patient Initials)

_____ Breast(s).
(Patient Initials)

_____ Perianal region, rectum, and/or buttocks.
(Patient Initials)

_____ I refuse to permit a chaperone for a Medical Appointment, Exam Involving Disrobing, or Sensitive Exam (circle all that apply).

I understand that the presence of a chaperone is required for an Exam involving Disrobing or a Sensitive Exam, or has been requested by me ___ or ____ the healthcare provider for a Medical Appointment.

An explanation of the examination(s)/procedure(s) have/has been provided to me, and I have been informed about:

1) The nature of the examination/procedure.
2) The potential risks, benefits, and/or adverse effects, including potential problems related to the examination(s) or procedure(s) and related to the failure to permit it.
3) The likelihood of achieving treatment goals.
4) The reasonable alternatives to the proposed care.
5) The relevant risks, benefits, and adverse effects related to alternatives, including the possible results of not receiving care, treatment, and services.

I understand the information in this form and all of the blanks have been completed prior to my signing.

_____/____
(Patient Signature / Initials)

_____ _____
(Witness Signature) **(Date)**