

Directive to Physicians

For Persons Under 18 Years of Age

DIRECTIVE made this _____ day _____ (month year).

On behalf of _____ a qualified patient under the DIRECTIVE TO PHYSICIANS who is under 18 years of age I/we _____ being of sound mind, willfully and voluntarily make known my/our desire that his/her life not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time the patient whose name appears above has an incurable or irreversible condition caused by injury disease or illness certified to be a terminal condition by two physicians and if the application of life-sustaining procedures would serve only to artificially prolong the moment of his/her death and if his/her attending physician determines that his/her death is imminent or will result within a relatively short time without application of life-sustaining procedures I/we direct that such procedures be withheld or withdrawn and that he/she be permitted to die naturally.
2. On behalf of the said patient it is my/our intention that this DIRECTIVE shall be honored by his/her physicians as the final expression of my/our legal right to refuse medical or surgical treatment on behalf of the said patient and to accept the consequences from such refusal.
3. If the patient has been diagnosed as pregnant and that diagnosis is known to her physician this DIRECTIVE shall have no force or effect during the course of her pregnancy.
4. This DIRECTIVE shall be in effect until it is revoked. I/we understand that my/our authority to execute this DIRECTIVE on behalf of the above-named patient expires on his/her 18th birthday.
5. I/we understand the full import of this DIRECTIVE and I/we am/are emotionally and mentally competent to make this DIRECTIVE.
6. I/we understand that the desire of the above-named patient, if mentally competent, to receive life-sustaining treatment shall at all times supersede the effect of this DIRECTIVE.

Signed _____

City, County, and State of Residence _____

Indicate relationship to patient _____ Adult Spouse _____ Parents _____ Legal Guardian

Two competent witnesses must sign below, acknowledging the signature of the person executing the DIRECTIVE on the minor patient's behalf. The witness designated as "Witness 1" may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. The witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. The witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of the health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of the health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____

Witness 2 _____

TEXAS LAW DOES NOT REQUIRE THIS DIRECTIVE TO BE NOTARIZED.