



# University of the Virgin Islands



## MEDICAL CONSENT FOR TREATMENT

### Contact Information: Health Services Center

Albert A. Sheen Campus (St. Croix)  
RR#1 Box 10, 000 Kingshill  
St. Croix, VI 00850-9781  
(340) 692-4208 (Office)

Orville E. Kean Campus (St. Thomas)  
#2 John Brewers Bay  
St. Thomas, VI 00802-9990  
(340) 693-1124 (Office)

### **MEDICAL CONSENT** (to be completed by the parent or guardian if student under age 18 or by the student if 18 or greater)

I, the undersigned (parent/guardian or student) do hereby grant permission to the University of the Virgin Islands Health Service Center (personnel, medical providers and nurses, or the medical provider designated by the campus physician) to provide medical and or surgical treatment to:

\_\_\_\_\_  
NAME OF CANDIDATE FOR ADMISSION

during her/his enrollment at the University of the Virgin Islands. I also grant permission for her/his hospitalization and treatment herein, if such hospitalization is necessary.

I understand that in the event of a serious illness, accidental injury or need for surgery, an attempt will be made by the University's Health Service Center to contact me by telephone. If unable to contact me, emergency treatment may be given as necessary in the best interest of the student.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN/STUDENT  
SIGNATURE OF STUDENT (IF OVER 18 YEARS OLD)

\_\_\_\_\_  
DATE  
(Month / Day/ Year)

\_\_\_\_\_  
PRIMARY CONTACT NUMBER