St. Thomas East End Medical Center Corporation
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"Your Health is our First Priority"

Medical Treatment Authorization Form for Minors

This form grants authority to the designated adult to allow St. Thomas East End Medical Center Corporation (STEEMCC) to provide behavioral, medical, and/or dental care for a minor (a person under the age of 18) in the event of an emergency, or where the minor is not accompanied by either a parent, or legal guardian, and it may not be feasible or practical to contact them. This form should be filled out, signed, given to, and kept on file with STEEMCC.

I, ____ residing at ________________________________
(Name of Parent/Legal guardian) (Address)

in St. Thomas/St. John, Virgin Islands, affirm that I am the parent or legal guardian of the child listed below and that there are no court orders now in effect, that would prohibit me from conferring the power to consent upon another person.

Minor Information

Minor's Name:____Date of Birth:__________________
Address: ____
City: ____________________________________State: ___________________ Zip Code:_______________
Phone: ______________________________ Gender: ☐ Female ☐ Male

Relationship to patient: ____

Information for Medical Treatment: Physician's Information

Name: ______________________________ Address: _______________________________________
City: _______________________________ State: ________________________ Zip Code:_______________
Phone: ______________________________ Insurance Company:_____________________________________
Policy#:_____________________________

Allergies to Medication(s):

Allergies (Other):

Please note all condition(s) for which the child is currently receiving treatment:

Any other significant medical information:

I hereby authorize ____ residing at ____________________________,
Name of Designated Adult Designated Adult Address

in St. Thomas/ St. John to accompany my child, _______________________________________, and consent to
(Minor's Name)

any reasonable and necessary medical treatment or examination performed at or given by St. Thomas East End Medical Center Corporation (STEEMCC).

The purpose of this document is to give ____:
(Designated Adult)

- ☐ The power and authority to consent to any reasonable and necessary medical treatment or examinations at STEEMCC for me in the event I am unavailable to do so.
- ☐ To facilitate/assist in making or coordinating appointment(s).
- ☐ To facilitate/assist in coordination of prescription(s)/refill(s).
- ☐ Other:____

This medical authorization form will take effect as of ____.
Date

Authorization

- I give this medical authorization freely and knowingly.
- I agree to assume financial responsibility for medical services provided to my child by STEEMCC.
- This medical authorization will remain in effect until it is revoked by notifying St. Thomas East End Medical Center Corporation, in writing.
- It is understood that this authorization is given in advance of any medical treatment, but is given to provide authority and power on the part of the designated adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel of STEEMCC.

______________________________	______________________________	__________________
Parent/ Legal Guardian Name	Parent/ Legal Guardian Signature	Date
______________________________	______________________________	__________________
Witness Name	Witness Signature	Date

Sworn and subscribed before me this

____
Date

____
Notary Republic

My Commission Expires:______________________