UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
STUDENTS MEDICAL SERVICES

I N S T R U C T I O N S

Please, read the document carefully before signing it.

The University of Puerto Rico requires that the student registration will be conditioned to submitting the Medical Form properly complimented in Part A and B. The information requested in this document is confidential and will be for exclusive use of the Student Medical Services Office and will not be divulged without authorization of the student or his/her legal representative. The Students Medical Services Office of the Medical Sciences Campus will custody the medical record for a period of ten (10) years; after this time, the University will dispose of it.
Visit your Family Doctor to do the physical exam and the laboratory orders. The medical form must be accompanied by the following:
Check (√)

☐ A. Medical Form- **PART- A**- completed by the students and **PART B**- physical examination completed by a **physician.**

☐ B. Original Certificate of immunization (PVAC-3) that meets the immunization requirements for the current academic period.
(**Green paper** of the Department of Health of Puerto Rico)

	REQUIREMENTS FOR STUDENTS UNDER 21 YEARS OLD		**REQUIREMENTS FOR ADULTS (21 YEARS OLD AND OLDER)**
	1. A booster shot for tetanus, diphtheria and acellular pertussis (TDAP) and tetanus booster against tetanus and diphtheria (TD), as applicable.		1. A booster shot for tetanus, diphtheria and acellular pertussis (TDAP) and tetanus booster against tetanus and diphtheria (TD), as applicable.
	2. Two dose of MMR (or two dose of Measles, two dose of German Measles and two of Mumps administered individually.		2. Two dose of MMR (or two dose of Measles, two dose of German Measles and two of Mumps administered individually.
	3. Three dose of Hepatitis B.		3. Three dose of Hepatitis B.
	4. Three dose of Polio vaccine.		4. Seasonal Influenza vaccine.
	5. Seasonal Influenza vaccine.		5. Two dose of Varicella vaccine or Varicella Titers IgG Quantitative (blood test).
	6. Two dose of varicella vaccine or varicella titers IgG Quantitative (blood test).		
	C. Results of the Tuberculine Skin Test (PPD) or Quantiferon Test. (No more than three months made the start date of classes).		C. Results of the Tuberculine Skin Test (PPD) or Quantiferon Test. (No more than three months made the start date of classes).
	D. Chest Plate (only for persons that have positive test of Tuberculine Skin Test).		D. Chest Plate (only for persons that have positive test of Tuberculine Skin Test).
	E. Blood exams results for syphillis serology. (No more than three months made the start date of classes).		E. Blood exams results for syphillis serology. (No more than three months made the start date of classes).
	F. Hepatitis B Surface Antibodies Quantitative- only for students that already were administered the three dose vaccine.		F. Hepatitis B Surface Antibodies Quantitative- only for students that already were administered the three dose vaccine. Must provide evidence of immunity.
	G. Physical Examination- see attachment		G. Physical Examination- see attachment
	H. Consent for the use and disclosure of health information- see attachment		H. Consent for the use and disclosure of health information- see attachment
	I. Affidavit authorizing services for under 21 years old (see attachment)		I. Affidavit authorizing services for under 21 years old (see attachment)
	J. A color photo 2 x 2		J. A color photo 2 x 2

Click on the following link to view documents for exemption from immunization for medical or religious reasons: https://de.rcm.upr.edu/wp-content/uploads/sites/13/2020/03/Vacunas-Exencion-Depto-Salud.pdf

PLEASE SEND THIS DOCUMENT WITH ALL LABORATORIES, TESTS, VACCINES AND PHOTO ENCLOSED TO: **serviciosmedicosestudiantes.rcm@upr.edu** (DOCUMENTS WILL ONLY BE ACCEPTED THROUGH DIGITAL METHOD PDF 300DPI RESOLUTION AND EACH SHEET IN INDIVIDUAL FILE).

PARTIAL DOCUMENTS WILL NOT BE ACCEPTED, THE SAME MUST BE DELIVERED IN THEIR TOTALITY.

UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
STUDENTS MEDICAL SERVICES

PASTE A COLOR PHOTO 2 X 2 HERE

PART A

STUDENT INFORMATION

(Information to be completed by the student)

Name_____ **Student Number**_____

Program to be admitted: _____ **Phone** _____

Status: Single ___ **Married**____ **Widow**____ **Divorced**____ ***Gender: Female***___ ***Male*** ____ ***Age:***____

Date of birth _____ ***Place (Country or State):***_____

Postal address: _____

EMAIL: _____

Physical address: _____

Father's name:_____ **Mother's name**: _____

In case of emergency, notify _____ **relationship:** _____ **Tel.** _____

Second call in case of emergency: _____ **relationship:** _____ **Tel.** _____

MEDICAL HISTORY

To circulate the illnesses that has in the present or that has had in the past:

Chicken pox	Sinusitis	Cardiac Problems	Chronic Intestinal Problems
Measles	Frequent Throat Infection	Hypertension	Hepatitis
Mumps	Tonsillitis	High Cholesterol	Renal disease
Rubella	Mononucleosis	Diabetes	Epilepsy
Poliomyelitis	Bronchial Asthma	Hypoglycemia	Emotional Alterations
Mumps	Hemophilia	Thyroid Disease	Psychiatric Disease
Diphtheria	Bronchitis	Skin Disease	Severe Trauma
Scarlet fever	Pneumonia	Eczema	Orthopedics Problems
Frequent Cold	Tuberculosis	Ulcers	Speech Defects
Otitis Media	Rheumatic Fever	Rheumatoid Arthritis	Cancer
Hearing defects	Zika	Mayaro Fever	Sexually Transmitted Infections
Dengue	Chikungunya	Others:	

Hospitalization or surgeries in the last year_____

Allergies to a medication or food_____

Others health problems_____

Medical treatment if any. Comments:_____

I acknowledge that not having immunizations up to date as required may represent difficulties upon doing clinical practices at certain centers.

_____ _____ _____ _____

Date Student Signature Date Parent or guardian

PART B

PHYSICAL EXAM

(to be filled by the doctor)

Name:_____

Age: _____ **Gender**_____ **Weight**_____ **Height**_____ **Blood Pressure**_____ **Pulse** _____

Visual Acuity: Right Eye_____ Left Eye_____ **Audition**: Right Ear:_____ Left Ear:_____

Clinic Evaluation by system	**Mark (√) yes or no evaluated**		**Comments:**
	Yes	**No**	
Skin			
Ears, nose & throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Urogenital			
Musculoskeletal			
Neurologic			
Serology of Syphilis (V.D.R.L.) Date:			Results:
Tuberculin skin test (if positive, results of Chest X Rays) Date of lecture:			Results:_____ mm
*Quantiferon Gold Blood Test Results Date:_____			Results:_____
Chest X Rays (if your tuberculin skin test is positive) Date: Results:			

***See instructions sheet**

ATTACH ALL LABORATORY RESULTS AND CERTIFICATE OF IMMUNIZATION OF YOUR COUNTRY OR STATE

Answer yes or no. REMARK YOUR REPLY TO BE AFFIRMATIVE

QUESTIONS	Yes	No	COMMENTS
Does the student have a significant problem of health or disability?			
Is he or she receiving any treatment for any physical or mental condition?			
Does he or she present any contraindication to participate in sport activities that require physical effort?			
Does he or she require any special management of a health condition or requires some reasonable accommodation while studying at the Medical Sciences Campus of the University of Puerto Rico?			

_____ _____ _____ _____

Exam Date **Doctor's Name** **Doctor's Signature** **Lic. No.**

Medical Office Seal_____

SERVICES AUTHORIZATION FORM
FOR STUDENTS THAT ARE MINORS OF 21 YEARS OLD

I_____ and living in _____
Father's or Legal Tutor Name (country or state)

I authorize the personnel authorized by the Honorable Secretary of Health of Puerto Rico in any branch of the medicine and that lend their services in the Departments or Medical Offices Services of the campus of the University of Puerto Rico, to that they offer the medical attention that is necessary that my son or (daughter)

_____ with the purpose of preserve Student
name

the health or to reduce the damage or incapacity that can arise to consequence of an accident or illness while study or practice some sport in the campus of the University of Puerto Rico or in any another structure not belonging to the same and diagnostic, treat, operate or practice those measured therapeutic or corrective that creates pertinent and besides administer the medicines and/or processing that are prescribed of conformity with the Laws of Puerto Rico. I authorize to be referred to other doctors and/or medical institutions properly accredited by the State Health's Department.

In_____, today, _____, 20_____
State or county date

_____ _____
Parent or guardian Student Signature

_____ _____
Driver License Number UPR Student Number or Driver License Number

AFFIDAVIT NO._____

I declare that the person who signed this document is personally known to me and I believe him or her to be capable of making health decisions. He or she signed this document in my presence.

SEAL AND FIRM OF THE NOTARY

SERVICES AUTHORIZATION FORM FOR STUDENTS THAT ARE:

(Select one)

21 years or more _____ married_____

I_____ and living in _____
Student's Name County or State

I authorize the personnel authorized by the Honorable Secretary of Health of Puerto Rico in any branch of the medicine and that lend their services in the Departments or Medical Offices Services of the Campus of the University of Puerto Rico, to that they offer the medical attention that is necessary to me with the purpose of preserve my health or to reduce the damage or incapacity that can arise to consequence of an accident or illness while study or practice some sport in the Campus of the University of Puerto Rico or in any another structure not belonging to the same and diagnostic, treat, operate or practice those measured therapeutic or corrective that creates pertinent and besides administer the medicines and/or processing that are prescribed of conformity with the Laws of Puerto Rico. I authorize to be referred to other doctors and/or medical institutions properly accredited by the Health's Department of Puerto Rico.

In_____, today, _____, 20_____
State or county date

_____ _____
Student Signature UPR Student number or Driver's License Number

UNIVERSITY OF PUERTO RICO

MEDICAL SCIENCES CAMPUS
PO BOX 365067
SAN JUAN PR 00936-8344
serviciosmedicosestudiantes.rcm@upr.edu

CONSENT STUDENTS MEDICAL SERVICES
FOR USE AND DIVULGE PROTECTED HEALTH INFORMATION

Name: _____ **Student Number**:_____

Of conformity with the Article 11, of the Law No. 194 of the 2000, Letter of Rights and Responsibilities of the Patient one, has the right of consenting to permit that its information of health protected be utilized and divulged for purposes of Processing, Payment and Activities Related to the Care of Health. At the moment of requesting services for first time, they will receive a copy of our Health Insurance Portability and Accountability Act.

Treatment: Your information of health can be shared among our doctors, employees, residents or another personnel, authorized to participate in your medical care, with the purpose of offering you a quality service.

Payment: Every activity directed to invoice and to collect for the services and medical processing offered.

Activities Related with Health Care: Activities of our company, for example, programs of training for professionals, auditory and activities for improvement of quality of service.

You have the right to restrain the use and divulgation of your health information protected to carry out the operations of Processing, Payment or Health Care Activities. Nevertheless, the Student's Medical Services Office is reserved the right of not accepting its restriction if the same one puts in risk the quality service offered or if the disclosure is required for State Law Department, regulation or by judicial order.

You have the right of revoke the consent at any moment in writing. The revocation will be effectiveness prospect and did not apply to disclosures performed based in the original consent.

CONSENT

This consent will be effective at the moment you that you sign it and delivery the medical documents to our Office.

I certify that I have read the dispositions of this consent, that I understand it and that I am of agreement with the terms conditions mentioned in the document.

_____ Patient Sign

_____ Date

_____ Father, Mother or Guardian Sign

_____ Father, Mother or Guardian Name

_____ Date

*Note: When the patient is smaller of 21 years, and is not emancipated, should bring this document signed by his or her parents or guardian.

RECINTO DE CIENCIAS MÉDICAS
SERVICIOS MÉDICOS A ESTUDIANTES
PO BOX 365067
SAN JUAN PR 00936-8344
Tel (787) 758-2525 Exts. 1215 y 1216

DECLARACIÓN JURADA PARA ESTUDIANTES MENORES DE 21 AÑOS

Yo, _____y vecino de_____, Puerto Rico,
Nombre del padre o tutor pueblo

faculto al personal autorizado por el Honorable Secretario de Salud de Puerto Rico en cualquier rama de la medicina y que preste sus servicios en los Departamentos u Oficinas de Servicios Médicos de los Recintos y Colegios de la Universidad de Puerto Rico, a que brinden la atención médica que sea necesario a mi hijo(a)_____
Nombre completo del menor

con el fin de preservar la salud o reducir el daño o incapacidad que pueda surgir a consecuencia de un accidente o una enfermedad mientras curse estudios o practique algún deporte en las Instalaciones del Recinto o Colegio o en cualquier otra estructura no perteneciente a los mismos y que diagnostique, trate, opere o practique aquellas medidas terapéuticas o correctivas que crea pertinentes y además administre los medicamentos y/o tratamientos que sean prescritos de conformidad con las Leyes del Gobierno de Puerto Rico. Autorizo a ser referido(a) a otros médicos y/o instituciones hospitalarias debidamente acreditadas por el Departamento de Salud del área.

En _____, hoy día____ de_____de _____.
Pueblo Mes Año

_____ _____
NOMBRE DEL PADRE O TUTOR FIRMA DEL ESTUDIANTE (MENOR)

_____ _____
FIRMA DEL PADRE O TUTOR NÚMERO DE ESTUDIANTE

AFFIDAVIT NÚMERO:_____

JURADA Y SUSCRITO ANTE MÍ por _____

de las circunstancias personales antes expresadas, y a quien doy fe de conocer personalmente en

_____, Puerto Rico, hoy día____de_____ de _____.

SELLO Y FIRMA DEL ABOGADO NOTARIO

GOBIERNO DE PUERTO RICO

Departamento de Salud

FORMULARIO

CONSENTIMIENTO POR REPRESENTACIÓN PARA TRATAMIENTOS MÉDICOS NO URGENTES A MENORES DE EDAD

La Ley Núm. 139 del 1 de agosto de 2019, conocida como la "**Ley de Consentimiento por Representación para Tratamiento Médico no Urgente a Menores de Edad**", tiene el propósito de permitir que las personas con patria potestad brinden su consentimiento para que los menores puedan recibir tratamientos médicos no urgentes.

Según establece la Ley Núm. 139, **supra,** se autorizan tratamientos médicos no urgentes a menores de edad sin ser necesaria la presencia de la persona con patria potestad del menor, siempre y cuando, la persona con patria potestad haya autorizado previamente la prestación de estos servicios.

Se entenderá como "**Tratamientos Médicos No Urgentes**" aquellos tratamientos médicos que no son emergencia. Esto Incluye tratamientos rutinarios o de seguimiento, tales como: servicios ambulatorios, servicios dentales, servicios de rayos X, exámenes de laboratorio, servicios de inmunización o cualquier otro servicio de salud que cumpla con las características mencionadas.

Para que este consentimiento sea efectivo la persona que tenga la patria potestad tiene que ser competente; deberá suscribir el presente consentimiento previo a que se brinden los tratamientos médicos y deberá suscribirlo ante la presencia del proveedor del servicio médico o su personal administrativo. La persona con patria potestad deberá especificar los tratamientos o servicios médicos no urgentes autorizados, así como, los no autorizados.

El consentimiento por representación deberá ser firmado por al menos una de las personas con patria potestad sobre el menor. La vigencia de este consentimiento será indicada por el padre custodio y no podrá ser por un periodo mayor a un (1) año. Esta vigencia será a partir de la firma del mismo.

Al momento del tratamiento, el menor de edad debe estar acompañado de un adulto previamente autorizado de acuerdo a la voluntad de la persona con patria potestad. El adulto autorizado debe acreditar su identidad mediante una identificación oficial. La identidad se podrá acreditar mediante licencia de conducir, pasaporte u otra identificación expedida por el Gobierno de Puerto Rico o estado con firma y foto.

En todo caso, los tratamientos médicos no urgentes serán ofrecidos por profesionales autorizados por el Estado a ejercer su profesión. El profesional autorizado mantendrá copia del consentimiento por representación, debidamente completado y firmado, en el expediente médico del menor.

(FORMULARIO CONSENTIMIENTO POR REPRESENTACIÓN PARA TRATAMIENTOS MÉDICOS NO URGENTES A MENORES DE

INFORMACIÓN DEL PACIENTE

Nombre del Paciente _____

Edad _____

Núm. Expediente _____

INFORMACIÓN DE PERSONAS CON PATRIA POTESTAD

Nombre de la persona _____
Edad _____

Relación con el menor _____

Identificación Oficial _____

Dirección _____

_____

Teléfonos _____

Correo electrónico _____

Nombre de la persona _____
Edad _____

Relación con el menor _____

Identificación Oficial _____

Dirección _____

_____

Teléfonos _____

Correo electrónico _____

INFORMACIÓN DEL ADULTO AUTORIZADO A ACOMPAÑAR AL MENOR

_____

Nombre de la persona
Relación con el menor _____

Edad _____

Identificación Oficial _____

Dirección _____

_____

Teléfonos _____

Correo electrónico _____

AUTORIZACIÓN

Yo, _____ (Persona con Patria Potestad) autorizó a

_____(Persona autorizada) a acompañar al menor _____ a recibir los siguientes servicios médicos no urgentes:

Descripción del Servicio o Tratamiento Médico Autorizado
1.
2.
3.
Descripción del Servicio o Tratamiento Médico <u>No Autorizado</u>
1.
2.
3.

FIRMAS:

Persona con patria potestad: _____

Fecha: _____

Periodo o Término de la autorización: _____

Acompañante: _____

Fecha: _____

Para ser llenado iniciado por el proveedor del servicio médico o su personal administrativo

A mi mejor conocimiento, la persona con patria potestad que autoriza los tratamientos médicos no urgentes al menor de edad, sin su presencia, es una persona competente.

La presente autorización ha sido suscrita previo a que se brinden los tratamientos médicos no urgentes al menor.

La presente autorización ha sido suscrita por la persona con patria potestad ante mi presencia.

_____

Proveedor de Servicio o Personal Administrativo Autorizado

De conformidad con la Ley 139-2019, no incurrirá en responsabilidad civil el profesional autorizado o la institución que ofreció el tratamiento a un menor de edad al cumplir con los requisitos de esta Ley y cuente con el presente consentimiento. Esto solo aplica a ofrecimiento de tratamiento y/o atención médica, no a las acciones u omisiones negligentes que pudiera incurrir el profesional de la salud en la administración del tratamiento.