UNIVERSITY OF PUERTO RICO
RIO PIEDRAS CAMPUS
OFFICE OF THE DEAN OF STUDENTS
MEDICAL SERVICES DEPARTMENT

MEDICAL FORM

□ Readmission
□ Admission
□ High School Student
□ Transfer from another university
□ Transfer (UPR campus)
□ Graduate / International Student

Academic Session
August 20_____
January 20_____
Summer 20_____

Please read carefully these instructions before filling out the **Medical Form**.

Every candidate for registration at the University of Puerto Rico, Río Piedras Campus, is required to submit a **Medical Form** with parts A and B properly completed. Fill out Part A before you see your doctor. Your doctor should fill out part B, using as references the required laboratory tests and examinations, including a Certificate of Vaccination, as established by Law 25 of the Commonwealth of Puerto Rico.

Have you been evaluated in this department before? ( ) Yes ( ) No Year _____

Requirements:

Each student shall complete medical form and summited the followings documents:

1. An immunization report (PVAC-3 original form) for students under 21, except international students of any age. PVAC 3 must be documented on both sides. Certification of immunization requirements must be documented on the back.
    a. Any disease that the student has suffer any infectious disease for which an immunization is required, will have to present evidence according to Law 25 of his/her exemption status. For more information go to the following web site: https://www.salud.gov.pr/Dept-de-Salud/Documents/Division%20de%20Inmunizacion/Exencion%20a%20Vacunar%20por%20Razones%20Medicas%20o%20Religiosas.pdf.
2. TB skin test results shall be specified on millimeters, if positive a chest X-ray is needed**. Athlete and international students must provide both tests. To international students x rays reports must have been done with the last six months prior to enrollment and TB test must be done in Puerto Rico.**
3. Blood tests (VDRL - serology).
4. Authorization to receive medical treatment. Students under 21 must present affidavit authorizing treatment
5. Consent to the use or disclosure of health information - HIPPA Law.

PART A - To be completed by the student

Name _____ Student number _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____

Sex _____ Age _____ Date of Birth _____ Birth Place _____
Day-Month-Year

Father's Name _____ Mother's Name _____

Mailing Address: _____ Telephone ( ) _____

Permanent Address: _____ Telephone ( ) _____

In case of emergency please contact _____ Relationship _____Tel. ( )_____

Second option in case of emergency _____ Relationship_____Tel. ( )_____

Email:_____

Emancipated: No □ Yes □ **Evidence must be provided (Original or Copy)**

Part A - Continue

Indicate any current or past history of any of the following;

	Chickenpox		Eating disorders		Unconsciousness		Chronical Intestinal Problems
	Measles		Sinus		Heart Diseases		Hepatitis
	Common Measles		Frequent Throat Infection		Hypertension		Renal Diseases
	German Measles		Tonsillitis		High Cholesterol		Epilepsy
	Poliomyelitis		Mononucleosis		Diabetes		Emotional Disorders
	Mumps		Bronchial Asthma		Hypoglycemia		Psychiatric Diseases
	Diphtheria		Anemia		Thyroid Disorder		Severe Traumatism
	Scarlet Fever		Hemophilia		Skin Disorders		Orthopedic Disorders
	Frequent Flu		Bronchitis		Eczema		Speech Disorders
	Otitis Media		Pneumonia		Ulcers		Malignancy
	Auditory Secondary Defect		Tuberculosis		Rheumatoid Arthritis		Surgery
	Blood vomiting		Rheumatic Fever		Osteoarthritis		Kidney stone
	Malaria		Menstrual Disorders		Urological disorder		Bladder disorders

Hospitalizations and illnesses during last year _____

Drugs or food allergies _____

Actual medical treatment if any _____

You are taking any medication? Which? _____

Do you practice any sports? ___ yes ___ no. Which? _____

Date	Student signature	Date	Parents or legal guardian signature

Part B – Physical Exam (***To be filled by doctor)***

Sex ____ Age ____ Weight _____ Height _____ Blood Pressure _____ Pulse _____ Blood Type (if known) ___ Pos/___neg

Vision: with OD 20/___ OS 20/___ without OD 20/ OS 20/___ Daltonism ____ Hearing ____ Satisfactory ___ No satisfactory

Check the column. Write N.E. if not evaluated

Clinical Evaluation by System	Normal		Observations
	Yes	No	
Skin			
Ear, Nose and Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Urogenital			
Muscular-skeletal			
Neurological			

Laboratory Results

Serology		Date Realized	Results
Tb test, if positive Chest X/Ray	Date Adm.	Reading Date	Reading _____mm
Chest X/Ray	Date	Result	

SUMMARY OF DISCOVERIES FROM CASE HISTORY, PHYSICAL EXAMINATION AND REQUIRED LABORATORY TESTS

Questions	Yes	No	Explain affirmative answers
Does the student has a significant health problem or disability?			
Is the student receiving treatment for any physical or mental condition?			
Is there a counter-indication for participation in athletic activities where physical effort is required?			
Recommendations that would provide for optimal health care.			

Date	Doctor's Name	Doctor's signature	Medical License's number	Phone #

NOTE: All students prior enrollment should present at Register Office evidence of health insurance coverage. If evidence it's not provided the student will be bill for coverage under the university student health insurance coverage.

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