AUTHORIZATION TO RECEIVE MEDICAL TREATMENT
(SWORN STATEMENT)
MINOR STUDENT (UNDER 21)

I, _____ , _____ , resident of
parent or legal guardian marital status

_____ , _____ , hereby:
town or city country

Authorize any health care provider dully authorized by the Honorable Secretary of Health of the Commonwealth of Puerto Rico to practice medicine and who provides services in the medical services departments and offices of the University of Puerto Rico to give _____ ,
name of student
whatever medical attention may be necessary for preserving his/her health or minimizing the damage or incapacity that may result as a consequence of an accident or illness while he/she is enrolled in courses or practicing a sport at the facilities of the campus or college or at any other facility not pertaining to said campus or college and to diagnose, or engage in such therapeutic or corrective measures as may be deemed appropriate and also to administer such medications and/or treatments as may be indicated in accordance with the Laws of the Commonwealth of Puerto Rico. I authorize that he/she may refer patient to other doctors and/or hospitals duly accredited by the Puerto Rico Department of Health.

In _____, this _____ day of _____ , _____.
town / city

_____
Parent or guardian signature

AFFIDAVIT NUMBER: _____

SIGNED AND SWORN BEFORE ME BY _____ ,
whose personal circumstances are as above described.

Notary Public

_____
County Clerk Registration Number

_____
Signature

_____
Name

rev 2017