



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

MEDICAL FORM

GENERAL INFORMATION

Please read carefully these instructions before filling the document out. Students should submit the Medical Form (pages 1 and 2) to the Medical Services Department at the Centro Universitario from June 4<sup>th</sup> until August 19<sup>th</sup>, 2018.

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. Students must submit other documents that may apply. These documents and their description are below. The information submitted is confidential, and for exclusive use of the Medical Services Department. The information will not be given to anyone without the prior authorization of the student or a legal representative.

**SECTION A:** The student must complete the required information in this section. Please fill out this section with print letter. A parent or legal guardian should signed if the student is younger than 21 years old. Should a legal guardian sign, the student must present evidence of the court's decision.

**SECTION B:** A physician must complete Section B. In order for a physician complete this section, the students must realize a tuberculin test, a serology test (VDRL), and a urine test. If the tuberculin test results are positive, the student should get a chest x-ray. A tuberculin test and a chest x-ray is **REQUIRED** to **student athletes** and **international students**. International students must do the tuberculin test in Puerto Rico, and their chest x ray reports' date should not exceed a year from the starting day of the semester.

Each student must complete the medical form and submit the followings documents:

1. An immunization certificate (PVAC-3 original form) is required for every student, including internationals, under 21. Certification of immunization requirements must be documented on the back. International students older than 21 years old must provide evidence of immunization according to their country of precedence.
  - a. If the student has suffered any infectious disease for which an immunization is required, will have to present evidence of their exemption status according to Law 25.
  - b. For more information go to the following web site: <http://www.salud.gov.pr/Dept-de-Salud/Documents/Division%20de%20Inmunizacion/Requisitos%20de%20Vacunaci%C3%B3n%20para%20el%20Curso%20Escolar%202017-2018.pdf>
  - d. If the student does not present the PVAC-3 for having accepted the exemptions provided by said law, he must present the sworn declaration form. You can find the form on the following link: <http://www.salud.gov.pr/Dept-de-Salud/Documents/Division%20de%20Inmunizacion/Exencion%20a%20Vacunar%20por%20Razones%20Medicas%20o%20Religiosas.pdf>
2. Authorization to receive medical treatment. Students under 21 must present an affidavit authorizing treatment.
3. Consent to the use or disclosure of health information - HIPPA Law.

**Transfer students within the UPR system**

**Younger than 21 years old:** should request a copy of their medical form, affidavit, and original PVAC-3 at their campus of origin.  
**21 years old or older:** request a copy of the medical form at their campus of origin.

**If the campus of origin does not provide these documents, the student must submit the documents from the Medical Services Department at UPRR.**



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**MEDICAL FORM**

- Admission
  - High School Student
  - Transfer from another university
- Readmission
- Transfer (within the UPR system)
- Graduate
- International Student

**Academic Session**  
 August 20 \_\_\_\_\_  
 January 20 \_\_\_\_\_  
 Summer 20 \_\_\_\_\_

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

**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

Email \_\_\_\_\_@upr.edu Other email \_\_\_\_\_

Mailing Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Permanent Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_ Relationship \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Second option in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

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

Hospitalizations and illnesses during last year \_\_\_\_\_

Drugs or food allergies \_\_\_\_\_

Actual medical treatment if any \_\_\_\_\_

Are you 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 a physician)*

Sex \_\_\_\_ Age \_\_\_\_ Weight \_\_\_\_ Height \_\_\_\_ Blood Pressure \_\_\_\_ Pulse \_\_\_\_ Blood Type (if known) \_\_\_\_ Positive or Negative

Vision: OD 20/ \_\_\_\_ OS 20/ \_\_\_\_ without OD 20/ \_\_\_\_ OS 20/ \_\_\_\_ Color-blindness \_\_\_\_

Hearing \_\_\_\_ Satisfactory \_\_\_\_ Unsatisfactory

Check the column for yes or no. Write N.E. if not evaluated

Clinical Evaluation	Normal		Observations
	Yes	No	
Skin			
Ear, Nose and Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Urogenital			
Muscular-skeletal			
Neurological			
Laboratory Results			
Serology	Date		Results
Tb test, if positive Chest X/Ray	Date Adm.	Reading Date	Reading ____ mm
Chest X/Ray	Date	Result	
CBC y differential	Date		Results
Urinalysis	Date		Results

## 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?			
Are there 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 Registrar Office evidence of health insurance coverage. If the student does not provides evidence, the UPR will bill the student for coverage under the university student health insurance.