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 Student Center from May, 27th until August 9th, 2019.

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, serology test (VDRL), CBC, 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 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 UPRRP.

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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

REV. April 2018

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.