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 Medical Sciences Campus, in compliance with Act No. 25 of 1983, requires all applicants to submit an up-to-date P-VAC-3 Immunization Certificate issued by the Puerto Rico Department of Health, including a Tdap or Td booster. However, certain academic programs at the Campus have vaccination requirements in addition to the Campus's general requirements. Therefore, when applying for admission, each applicant is responsible for obtaining information about and complying with the additional vaccination requirements established for their academic program.

The University of Puerto Rico requires that student registration will be conditioned on submitting the Medical Form properly completed in Parts 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 Student 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 doses of MMR (or two dose of Measles, two dose of German Measles and two of Mumps administered individually.		2. Two doses of MMR (or two dose of Measles, two dose of German Measles and two of Mumps administered individually.
	3. Three doses of Hepatitis B.		3. Three doses of Hepatitis B.
	4. Three doses 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 doses 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 syphilis serology. (No more than three months made the start date of classes).		E. Blood exams results for syphilis 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. A color photo 2 x 2		I. A color photo 2 x 2

UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
STUDENT 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_____

Other 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:

(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 DISCLOSURE OF 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 health information can be shared among our doctors, employees, residents, or other personnel authorized to participate in your medical care, for 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 agree with the terms conditions mentioned in the document.

_____ _____
Patient Sign Father, Mother or Guardian Sign

_____ _____
Date Father, Mother or Guardian Name

_____
Date

*Note: When the patient is under 21 years of age and is not emancipated, they must bring this document signed by their parents or guardian.