SERVICES AUTHORIZATION FORM
FOR STUDENTS THAT ARE MINORS OF 21 YEARS OLD

I_____ and living in _____
Father's or Legal Tutor Name (country 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 that my son or (daughter)

_____ with the purpose of preserve Student
name

the 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 State Health's Department.

In_____, today, _____, 20_____
State or county date

_____ _____
Parent or guardian Student Signature

_____ _____
Driver License Number UPR Student Number or Driver License Number

AFFIDAVIT NO._____

I declare that the person who signed this document is personally known to me and I believe him or her to be capable of making health decisions. He or she signed this document in my presence.

SEAL AND FIRM OF THE NOTARY