UNIVERSITY OF PUERTO RICO AT CAYEY
DEAN OF STUDENTS
MEDICAL SERVICES
CAYEY, PR 00736

PICTURE 2x2

MEDICAL FORM

- o Re-admission
- o Admission
  - o Freshman
  - o Student from other private institution
- o Transfer from other institution of UPR system

Academic Session
August 20_______
January 20 _______
Summer20_______

INSTRUCTIONS

Please read this document carefully after filling it out

The University of Puerto Rico, establishes some requirements to accept students. They have to submit a Medical Form complimented in part A and B. The information required is confidential and it will be exclusive of the Medical Services Department. It will not be divulge without previous authorization of the student.

¿You have been evaluated in this Department? ( ) Yes ( ) No

All students will enclose this form with this documentation:

REQUIREMENTS

1. Immunization Certificate PVAC-3
   a) Three or more doses of diphtheria, peruses and tetanus (DPT/TD). A dose after 10 years from the last doses administrated.
   b) Three doses of polio or more. The last doses after the age of 4 (not required for orders of 18 years).
   c) Two doses of MMR (or two doses of common measles, two doses of German measles and two doses of mumps administrated individually). All the vaccines it has to be administrated before 12 months of birth. Any vaccine administrated before the year is consider useless.
   d) Three doses of Hepatitis B
2. Results of Tuberculosis and Chest X-Ray only at those who had a positive test. Athletes will require both.
3. Blood test results of Syphilis (serology)
4. Authorization to receive medical attention. Student's under 21 years must be notarized.
5. Medical Health Insurance evidence (copy of the health insurance card with expiration date or certification of the insurance company or the Human Resources Office of the agency).
6. Two photos 2x2 (optional)
7. Consent form to use or divulge Health Information-HIPAA law
8. Transfer student's, have to submit certificated copy of the authorization to receive medical attention and PVAC-3 in original of the institution

PLEASE RETURN THIS DOCUMENT TO THE SERVICES HEALTH DEPARTMENT OF THE UNIVERSITY OF PUERTO RICO AT CAYEY
REMEMBER THAT IS A REQUIREMENT TO HAVE A HEALTH INSURANCE WHILE YOU ARE STUDENT OF THE UPRC

PART A: THIS INFORMATION HAS TO COMPLETED BY THE STUDENT

Name ____ Student Num. __________________________

Civil Status ____ Single ____ Married ____ Divorce ____ Widower Social Security Number ________________________________

Birth ________________________________ Sex: ( ) F ( ) M Place of birth: ____

Month Day Year

Fathers Name: ____ Mothers Name _________________________________

Physical Address: ____ Telephone: __________________________

Postal Address: ____ Telephone: __________________________

In case of emergency notify to: ____ Relationship: ________________________

Emancipated ( ) yes ( ) no Present evidence (original or certificated copy)

PART A CONTINUATION
HEALTH HISTORY
(to be completed by the student)

Mark those illness or conditions you have in the present or in the past

	Chicken Pox		Diabetes		Hepatitis		Headache
	Measles		Weight Loss		Hemorrhoids		Sinusitis
	Common		High Cholesterol		Pain when Urinates		Epilepsy
	German		Sickle Cell Anemia		Kidney Infection		Convulsion
	Mumps		Cancer		Kidney Stone		Loss of Consciousness
	Tuberculosis		Chronic cough		Arthritis Lupus		Dizziness
	Meningitis		Pneumonia		Scoliosis		Eye Disease
	Depression		Bronchitis		Fractures		Deaf
	Bulimia		Stomach Ulcer		Use of Orthopedic Equip.		Frequent ear infection
	Sleeplessness		Frequent Diarrhea		Allergies		Nasal Bleeding
	Lost of Appetite		Stomach ache		Asthma		Throat Infection
	Throat Infection		Gums Disease		Thyroid Disease		Rheumatic Fever
	Suffered from Heart Disease		High Blood Pressure		Respiratory Difficulty		Breast Pain

Hospitalizations or illness in the last year ____

Allergies from some medicines or food ____

Other Health Problems____

Indicate actual treatment____

___________ Date

___________________________ Student's Signature

_____________ Date

___________________________ Parents or legal tutor's signature

PHYSICAL EXAM
(To be completed by the Doctor)

Sex _____ Age _____ Weight ______ Height ______ B. Pressure _____ Pulse _______ Visual Exam R. Eye ______ L. Eye______ Audition _____

CLINICAL EVALUATION BY SYSTEM	NORMAL		COMMENTS
	SÍ	NO	
Skin			
Ear, Nose and Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Urogenital			
Muscle Skeleton			
Neurotically			
Hematopoietic			
Other			

Serology	Date realized	Result
Tuberculin, if positive, Chest X Ray Date applied	Date of lecture	Lecture
Chest X Ray (if applied)	Date	Date Result

SUMMARY OF HISTORICAL FINDINGS, PHYSICAL EXAM AND LABORATORIES

QUESTIONS	YES	NO	COMMENTS YOUR AFFIRMATIVE ANSWER
¿ Does the student have significant or incapacitated health problem?			
¿Does the student is in medical treatment for a mental or physical condition?			
¿Does exists any contraindication to participate in Athletic Activities, ROTC and others?			
¿Does exists an special recommendation to manage the health problems that the student may have at UPR-Cayey			

Doctor's Name _______________________________ **Doctor's Signature** ____________________________________

License Number _____________________________ **Telephone** __________________________ **Date** ____________________