Universidad de Puerto Rico en Carolina
Decanato de Asuntos Estudiantiles
Oficina de Servicios Médicos

Authorization to Receive Medical Care Affidavit
Student under 21 years old

I, _____ , of legal age _____
Name of father, mother or guardian — Status

and neighbor of _____ , in my character of_____
Town/State — Relationship with the student

of_____ hereby Authorize:
Student name

The personnel who are empowered by the Honorable Secretary of Health of the Commonwealth of Puerto Rico in any branch of medicine and who provide their services in the Medical Services Departments or Offices of the University of Puerto Rico Campuses to give medical attention that is necessary in order to preserve health or reduce damage or disability that may arise as a result of an accident or illness while studying or practicing any sport in the facilities of the Campus or any other facility not belonging to them and that diagnoses, treats, operates or practices those corrective therapeutic measures that they deem pertinent and also administer the medications and / or treatments that are prescribed in accordance with the laws of the Commonwealth of Puerto Rico. I authorize it to be referred to other doctors and / or hospital institutions duly accredited by the Department of Health in the area, following the established privacy standards .- - - - - - - - - - - - - - -

In _____ (Town/State), today _____ (day) of _____

(month) of _____ (year).

_____
Signature of father, mother or guardian

_____
Student signature

_____
Students number

Affidavit Number: _____

SWORN AND SUBSCRIBED BEFORE ME by _____ of personal circumstances before expressed, and identified by your
❑ passport ❑ license number _____ , in _____ ,
today _____ (day) of _____ (month) of _____ (year)

NOTARY STAMP AND SIGNATURE

Authorization to Receive Medical Care Affidavit

❑ Over 21 ❑ Married ❑ Emancipated

I, ______________________________________ , ________________________________
Student name Status

and neighbor of ____ , hereby Authorize the
Town/State

personnel who are empowered by the Honorable Secretary of Health of the Commonwealth of Puerto Rico in any branch of medicine and who provide their services in the Medical Services Departments or Offices of the University of Puerto Rico Campuses to give medical attention that is necessary in order to preserve health or reduce damage or disability that may arise as a result of an accident or illness while studying or practicing any sport in the facilities of the Campus or any other facility not belonging to them and that diagnoses, treats, operates or practices those corrective therapeutic measures that they deem pertinent and also administer the medications and / or treatments that are prescribed in accordance with the laws of the Commonwealth of Puerto Rico. I authorize it to be referred to other doctors and / or hospital institutions duly accredited by the Department of Health in the area, following the established privacy standards .- -

In ____ , today ______ (day) of ____________

(month) of ________________________ (year).

___________________________ ______________________________
Student's signature Student number

Affidavit Number: ________________________

SWORN AND SUBSCRIBED BEFORE ME by ______________________________ of personal circumstances before expressed, and identified by your
❑ passport ❑ license number ________________________ , in ______________________ ,
today ______ (day) of ____________ (month) of ____________________ (year)

NOTARY STAMP AND SIGNATURE