Universidad Adventista de las Antillas

Vice-Presidency of Student Affairs
PO Box 118
Mayagüez, Puerto Rico 00681

MEDICAL AUTHORIZATION FORM FOR STUDENT RESIDENCIES

PART I. STUDENT'S PERSONAL INFORMATION

Surnames ____ **Name** ____

Age __________ **Gender** _______ **Date of Birth** ____________________________ **Blood Type**: ____________________

Are you allergic to any medication/food?: _____No _____Yes (Please Explain)

____

Do you have any medical condition that requires frequent use of medication?: ____ No ____ Yes (Please Explain)

____

Will this medication interfere with other medication or medical procedure? _____No _____Yes (Please Explain)

____

Do you have a significant or disabling health problem? _____No _____Yes (Please Explain)

____

Are you being treated for any physical or mental health condition? _____No _____Yes (Please Explain)

____

PART II. MEDICAL PLAN INFORMATION

Name of your Primary Doctor:____ **Doctor's Phone Number**: ____________________

Medical Plan: ____ **Contract Number:**_______________________________________

Principal Insurer: _______________________________________ **Expiration Date:** ___________________________________

PART III. CONTACT INFORMATION IN CASE OF AN EMERGENCY

Name of Mother or Guardian: ____

Postal Address: ____

Telephones: Home: ____________________________ **Cellphone**: __________________________ **Work**: _______________________

Alternative Telephone:___________________________________ **E-Mail**: ______________________________

Name of Father or Guardian: ____ **Postal Address**: ____

Telephones: Home: ____________________________ **Cellphone**: __________________________ **Work**: _______________________

Alternative Telephone:___________________________________ **E-Mail**: ______________________________

PART IV. AGREEMENT

I hereby authorize the Director of the Student Residencies, the Vice President of Student Affairs, or an official delegated by Antillean Adventist University in the event of an emergency, the management of medical services necessary for the student's health and well-being. ____, student number ________________________ with social security _____________________________ while living in Student Residences. I understand that the accompanying staff is not authorized to sign any documents related to admission to the hospital, medical documents, or any other that a health institution may require for my child to receive any treatments recommended by the medical service provider. I hereby agree to be present at the corresponding health institution as soon as possible, within a maximum period of 4 hours (if a resident of Puerto Rico) after being notified of a medical emergency. If I am not a resident of Puerto Rico, I agree to make the arrangements necessary to be present in Puerto Rico. The University will make the necessary arrangements to provide the student first aid, and once the situation is stabilized, its role regarding the provision of medical services will cease. With this authorization, I assume full responsibility for the hospital or health facility that offers medical services to my child.

I certify to have read this document and that I understand my responsibilities as a parent or guardian of the student.

Name of father/mother/guardian: ____

Signature of father/mother/guardian: ____ Date: ________________________

Student's Signature: ____ Date: ________________________