UNIVERSIDAD ADVENTISTA DE LAS ANTILLAS

Health Services Department

Personal Information Form & Authorization For Emergency Treatment

I. Emergency Contact Information

________________________ Last Name, First Name   ________ Age   ______________________________ Student Number

Sex: ___Feminine ___Masculine   Marital Status: ___Single ___Married

____________________________ Major   ____ Nickname

____________________________ Religion   ____ Nationality

Physical Address

____

____

Postal Address (**If different from physical address)**

____

____

Emergency Telephone Contact   Person To Notify In Case of Emergency

Day: ___________________________   Name: ___________________________________

Night: _________________________   Parent: _________________________________

Neighbor: ________________________   Existing Health Conditions ______________________

Other: ___________________________   ____

Allergies: ____________________   Blood Type: _________________________

Parent/Guardian Name: ____

Postal Address: ____

Phone Number: ______________________________

Universidad Adventista de las Antillas
Apartado 118
Mayagüez, PR 00681-0118
Tel. (787) 834-9595

Authorization for Medical Treatment

I, ____,

Parent / Guardian,

authorize the Health Services Department of Antillean Adventist University to perform/provide evaluations, medical treatment and over-the-counter medicines or medication with proof of prescription. I authorize any referrals to other hospitals or medical institution which are accredited by the Department of Health to treat (**student name**) _______________________________________, minor whom I possess all parental authority. I authorize the University nurse or an authorized physician to make necessary judgements when they are in accordance with the normal and prevailing practices in the field of medicine in Puerto Rico.

This authorization is valid while my son/daughter is a student at the University. I certify that I understand the information contained in this authorization form.

This authorization also applies to the services offered by primary care doctors and specialists provided by the student medical plan and/or whichever insurance plan the student has.

I understand that in case of any surgery or procedure which is not classified as an emergency I will be consulted prior to said surgery or procedure.

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THIS DOCUMENT WILL REMAIN IN THE STUDENTS MEDICAL FILE AND COPIES CANNOT BE MADE WITHOUT PRIOR AUTHORIZATION OF THE UNIVERSITY NURSE.

AFFIDAVIT NUMBER ___________________

Sworn and affirmed before me ______________________________ whom I attest I have met personally

in (city)______________________________, today ___________

(month)_____________________ (year) _______________.

____

Signature & Stamp of Notary/Lawyer