MEDICAL SERVICES OFFICE
P. O. Box 118
Mayagüez, PR
Tel. 787-834-9595
Ext. 2322

MEDICAL EVALUATION
PART I

student or Parent: Please provide the following information. All items must be completed. Please print.

PERSONAL INFORMATION

Name: _____ Birth Date: _____ / _____ / _____

Address: _____ Phone: ( ) _____

Email Address: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship: _____

Address: _____

Home Phone :( ) Work Phone :( ) . _____

MEDICAL HISTORY

Please indicate which illnesses or conditions you now have or you have previously experienced. Indicate by answering yes or no. For all yes responses indicate the year of onset or occurrence.

ILLNESSES	Yes	Year	No
Anemia	G	_____	G
Asthma	G	_____	G
Back Problem	G	_____	G
Bleeding Problem	G	_____	G
Cancer	G	_____	G
Colitis	G	_____	G
Depression	G	_____	G
Emotional Problem	G	_____	G
Epilepsy	G	_____	G
Fainting Spells	G	_____	G

	Yes	Year	No
Gonorrhea	G	_____	G
Heart Disease	G	_____	G
Hepatitis	G	_____	G
Hearing Problem	G	_____	G
Herpes	G	_____	G
High Blood Pressure	G	_____	G
Hypoglycemia	G	_____	G
Joint Problem	G	_____	G
Measles	G	_____	G
Mental Illness	G	_____	G

	Yes	Year	No
Migraines	G	_____	G
Rubella	G	_____	G
Suicide Attempt	G	_____	G
Syphilis	G	_____	G
Thyroid Disease	G	_____	G
Tuberculosis	G	_____	G
Ulcers	G	_____	G
Vision Problem	G	_____	G
Women: Severe Period Cramps	G	_____	G

SURGERIES	Yes	Year	No
Appendectomy	G	_____	G
Gallbladder Surgery	G	_____	G

	Yes	Year	No
Hernia Surgery	G	_____	G
Knee	G	_____	G

	Yes	Year	No
Spine Surgery	G	_____	G
Thyroid Surgery	G	_____	G

HOSPITALIZATIONS: List all hospitalizations, within the last 10 years, except surgeries listed above. Give year of occurrence.

ALLERGIES: List allergies with the reaction you experience. .

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MEDICATIONS: List name of any medication(s) you commonly take along with dose (how much you take) and frequency (how often you take it). .

HANDICAPS: So we may help provide for your needs, please list any physical handicaps which may require special equipment or accommodations. . . .

I the undersigned student **(if 21 years of age or older)** or the parent or guardian of the above named student **(if the student is 20 years of age or younger)** do hereby affirm that the above information is accurate and complete. I, the undersigned, do hereby authorize, in the case of illness or injury, any diagnostic or therapeutic examination, procedure, or treatment deemed advisable by and rendered under the supervision of the Student Health Physician or other health care providers selected by faculty, officers, or agents of UNIVERSIDAD ADVENTISTA DE LAS ANTILLAS or selected by the undersigned. Consent is hereby granted to the Student Health Service to release pertinent medical information to the aforementioned health care providers, and to give any test and/or immunization required of University Students if such test or immunization has not been completed or documentation of completion is lacking. Such test or immunization may include but may not be limited to measles, mumps, and rubella, tetanus, tuberculosis skin test, hemoglobin, and urine for glucose and protein.

Student _____ Dated _____

Parent or Guardian _____ Witness _____

MEDICAL EVALUATION
PART II

Care Provider: First, review the completed medical history on the reverse side of this form, and evaluate documentation of any tests or immunizations that have already been given. Next perform the necessary tests and examinations to complete this side of the form.

Student's Name: _____ Age: _____ F ( ) M ( )
Ht _____Wt _____ BP _____ /_____ Vision: O.D._____ /20 _____ Corrected
O.S. _____/20 _____ Uncorrected

EXAMINATION

	Norm	Abn	Details
Skin			
HEENT			
Neck			
Heart			
Lungs			
Breast			
Abdomen			
Hernias			
Back			
Extrem			
Reflexes			

Are there any physical deformities or limitations? NO _____ YES _____

(If yes, explain.) _____

Are there any physical or emotional illnesses or conditions that may require ongoing medical care? No _____ Yes _____

(If yes, explain). _____

Is there any medical treatment to be continued while this person is attending school? No _____ Yes _____

(If yes, explain.) _____

Care Provider's Signature _____ Date _____

Name (Print or Stamp) _____ Phone _____

Address _____ License # _____

Revised June 2015