Authorization for Medical Services

☐ **Over 21** ☐ **Married** ☐ **Emancipated**

I, _____, _____,
Student's Name Social Security Name

_____ ,and neighbor of _____, Puero Rico,
Status Municipality, Town, City

Allow personnel authorized by the Honorable Secretary of Health of the Commonwealth of Puerto Rico in any Branch of medicine and who provide their services in the Departments or Offices of Medical Services of the Campuses of the University of Puerto Rico to provide medical care that is necessary in order to preserve health or reduce the 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 to diagnose, treat, opérate or practice corrective therapeutic measures that they deem pertinente and also administer medications and/or treatments that are prescribed in accordance with the laws of the Commonwealth of Puerto Rico. I authorize a referral to other physicians and/or hospital institutions accredited by the Department of Health in the área, following the established privacy standards.-------

In _____, Puerto Rico, today _____.

_____ _____
Student's Signature Student Number