REQUIREMENTS

The following requirements are needed for your registration process

A. STUDENTS 21 YEARS OLD AND UNDER

1. An immunization report (PVAC-3 Form) which must include the following:
   a) At least three doses of DTP/TD and Polio Vaccines.
   b) TD dose no more than 10 years after last TD.
   c) Two doses of MMR (Mumps, Measles, Rubella). First vaccine must be given after 12 months of age. Second
dose must be given at least one month after first one.
   d) Students 18 years old and under must provide evidence of 3 doses of Hepatitis B.

Note: This immunization record is stated as a requirement under Puerto Rico Public Law #25 (September 25, 1983). Students
with incomplete immunization should provide appropriate medical certificates. If the student has no evidence of any
immunization record, he or she has to start a vaccination itinerary of TD, MMR and/or Hepatitis B as follows:

   TD: 
   - 1st dose given
   - 2nd dose, two months after first dose
   - 3rd dose, six months after second dose

   MMR: 
   - 1st dose
   - 2nd dose, thirty days after first dose

   Hepatitis B
   - 1st dose
   - 2nd dose, first month after 1st dose
   - 3rd dose, six month after 2nd dose

Students eighteen years old and under that do not show any evidence of immunization must start vaccination as already indicated
plus three doses of Hepatitis B.

2. Tuberculin test or Chest X-Ray reports must have been done within six months prior to entry.
3. VDRL and CBC results within six months prior to entry.
4. The Personal History and the Physical examination must be completed in all parts by a doctor in medicine and the
   Health Report and Physician’s Certificate must be completed by the student.
5. Two photographs 2x2 (optional).
6. Authorization for Diagnosis and/or Ambulatory Treatment must be completed by a public notary with the official seal.
7. Foreign or out of state students must have one of the University insurance coverage alternatives. Please refer for the
   attached document for insurance coverage information and costs.
8. HIPAA law and confidentiality act must be filled and submit in all parts.
9. Public Drugs and Alcohol Act must be filled and submit in all parts.

B. STUDENTS 21 YEARS OLD AND OVER:

1. One dose of TD. Last dose must have been administered within last ten years.
2. Tuberculin test or Chest X-Ray reports must have been done within six months prior to entry.
3. VDRL and CBC results within six months to entry.
4. The Personal History and the Physical examination must be completed in all parts by a doctor in medicine and the
   Health Report and Physician’s Certificate must be completed by the student.
5. Two photographs 2x2 (optional).
6. Authorization for Diagnosis and/or Ambulatory Treatment must be completed by a public notary with the official seal.
7. Foreign or out of state students must have one of the University insurance coverage alternatives. Please refer for the
   attached document for insurance coverage information and costs.
8. HIPAA law and confidentiality act must be filled and submit in all parts.
9. Public Drugs and Alcohol Act must be filled and submit in all parts.
HEALTH REPORT AND PHYSICIAN’S CERTIFICATE
Place print or type all information

Name: _____________________________ Social Security No: ___________ Student Number: ______________________

Last           First           Middle

Address: ____________________________________________________________________________________________________
Street
City
State
Zip

Parent or Guardian:
Address: ____________________________________________________________________________________
Street
City
State
Zip

Family History: (List all family diseases: Diabetes, Tuberculosis, Mental illness, and other):
____________________________________________________________________________________________________________

In case of emergency:
Name: ____________________________________________________________________
Address: __________________________
__________________________________________________________________________
Street
City
State
Zip

Phone number: _____________________       Work Place: _____________________
Area code- Number                Area code- Number

____________________________________________________________________________________________________________

PERSONAL HISTORY
Check those of the following diseases or conditions the student has had:

<table>
<thead>
<tr>
<th>Chicken pox</th>
<th>Measles</th>
<th>Emotional disorder</th>
<th>Mumps</th>
<th>Scarlet fever</th>
<th>Whooping cough</th>
<th>Diphtheria</th>
<th>Frequent colds</th>
<th>Frequent sore throats</th>
<th>Otitis media</th>
<th>Kidney disease</th>
<th>Sinusitis</th>
<th>Tonsillitis</th>
<th>Bronchitis</th>
<th>Malignancy</th>
<th>Malignancy</th>
<th>Asthma</th>
<th>Cholera</th>
<th>Rheumatoid arthritis</th>
<th>Hives</th>
<th>Speech pathology</th>
</tr>
</thead>
<tbody>
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</table>

Date of Birth: ______________

Injuries (severe): ______________________
____________________________________________________________________________

Days of illness last Year: __________
Cause: ____________________________________________
____________________________________________________________________________

Any drug of Food Allergies: __________
____________________________________________________________________________

Medical problems other than listed: ______
____________________________________________________________________________

Has applicant ever had psychotherapy? ______
____________________________________________________________________________

Has applicant ever use hand drug or been on methadone maintenance? ______
____________________________________________________________________________
PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Clinical Eval. (check each item in proper col. write N.E. if not evaluated)</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Details of abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Neck, Face and Scalp</td>
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<tr>
<td>Nose and Sinuses</td>
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<tr>
<td>Mouth and Throat</td>
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<tr>
<td>Teeth and Gingiva</td>
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<tr>
<td>Ears (Perf. Of drum etc.)</td>
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<tr>
<td>Eyes (Lids, Conjunctiva etc.)</td>
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<tr>
<td>Pupils and Ocular Motion</td>
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<tr>
<td>Lungs Chest and Breasts</td>
<td></td>
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<tr>
<td>Vascular System (Varicosities etc.)</td>
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<tr>
<td>Heart (Include estimate of cardiac function)</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Ano- rectal</td>
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<tr>
<td>Endocrine System</td>
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<tr>
<td>G-U System</td>
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<tr>
<td>Upper Extremities (Strength, range of motion)</td>
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<tr>
<td>Congenital Disease</td>
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<tr>
<td>Lower or Upper Extremities</td>
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<tr>
<td>Spine, other Muscle Skeletal Problem</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Neurological</td>
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<tr>
<td>Psychiatric Problems</td>
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<tr>
<td>Lab. Tests at discretion of examining physician:</td>
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<tr>
<td>Lymph</td>
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</tbody>
</table>

Is the student able to participate in all physical activities? Yes____ No____ If “No” what activities are able to be eliminated? ________________________________________________

Is there or has there ever been evidence of anxiety or emotional instability? ____ if yes please indicate how the college may be of help to this student. ________________________________________________

After considering the history and physical examination, what is your personal opinion of this applicant ability to meet the physical demands of college life? ________________________________

Do you recommend further investigation or treatment? __________

Exchanging Physician ___________________________ License # ________________

Sign: ___________________________ Date: ___________________________

Telephone: ___________________________

Sex: ____________          Age: ________________          Height: ______________          Blood / Pressure: ________________

Pulse: ________________       Slender: ______ Medium: ______ Heavy ______ Obese: ______

Color: ___________________________ Hearing: ______ Right: ______ Left: ______


Street __________ City __________ State __________
AUTHORIZATION FOR DIAGNOSIS AND/OR AMBULATORY TREATMENT

Name: _____________________________  Student Number: ______________________________
Date of Birth: ____________________  Age: _________ Married ________ Yes ________ No
Name of Spouse: _____________________

I authorize the medical staff and personnel determined by the Health Service Department of University of Puerto Rico, Mayaguez Campus to perform the necessary routine diagnostic procedure(s) required by the medical or dental staff for evaluation, and or to give me medical treatment accordance with standard, prevailing medical practice or referral to other health service as needed.

I am aware that medicine is not an exact science, and that I have not been offered guarantees of the result the test(s) and/or treatment(s) to be given.

I hereby certify; (1) that I have read (or have had this read to me) this authorization for the medical procedures considered necessary as judged by medical staff of the Health Service Department of the University of Puerto Rico Mayaguez Campus; (2) that I understood thoroughly all the information given on the form; (3) that before I sign, all the paragraphs that I do not accept or don’t apply to my case, have been crossed out.

Date: _________________________  Time: ____________________________
Patient’s Signature:  Parent’s Guardian’s signature:
______________________  ____________________________

Public Notary (WITH SEAL)
FOR STUDENTS OF ALL AGES