

**STATEMENT**

**STUDENT UNDER 21 YEARS OF AGE**

I, \_\_\_\_\_, old enough, \_\_\_\_\_, living in  
**Parent or Legal Guardian name** **Civil Status**

\_\_\_\_\_, \_\_\_\_\_, in my character as a \_\_\_\_\_  
**City or Town** **Country** **Parent or**

\_\_\_\_\_, I state:  
**Legal Guardian**

I empower to the personnel authorize by the Honorable Secretary of Health of the Commonwealth of Puerto Rico, in any of it's medical branches serving the departments or medical offices pertaining to the campuses and schools of the University of Puerto Rico, to lend to my son/daughter the medical services deemed is necessary to preserve the health or minimize damage or incapacity that could arise as a result of an accident or disease while attending school or any other of campus facilities or schools or in any other facility not belonging to the UPR, and to diagnose, treat, perform surgery or to administer therapeutic corrective measures deemed necessary, moreover to prescribe the medicines and treatments necessary in accordance to the laws of the Commonwealth of Puerto Rico. I also authorize the referral of my son/daughter to other doctors and/or hospitality institutions duly credited by the Department of Health of Puerto Rico. \_\_\_\_\_

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Parent Signature or Legal Guardian**

\_\_\_\_\_  
**Student Number**

\_\_\_\_\_  
**S.S. Number of Parent or Legal Guardian**

\_\_\_\_\_  
Student Social Security Number

State of \_\_\_\_\_

County of \_\_\_\_\_

On \_\_\_\_\_ before me, \_\_\_\_\_,

Personally appeared \_\_\_\_\_, personally known to me by his/hers personal circumstances as expressed and of whom I attest to personally know.

**STAMP**  
**NOTARY PUBLIC'S SIGANTURE**

**STATEMENT**

**STUDENT:** \_\_\_\_\_ **Over 21 years old** \_\_\_\_\_ **Married** \_\_\_\_\_ **Emancipated**

I, \_\_\_\_\_, old enough, \_\_\_\_\_, living in  
**Student's Name** **Civil Status**  
\_\_\_\_\_, \_\_\_\_\_, in my character as a \_\_\_\_\_  
**City or Town** **Country** **Parent or**  
\_\_\_\_\_, I state:  
**Legal Guardian**

I empower to the personnel authorize by the Honorable Secretary of Health of the Commonwealth of Puerto Rico, in any of it's medical branches serving the departments or medical offices pertaining to the campuses and schools of the University of Puerto Rico, to lend to my son/daughter the medical services deemed is necessary to preserve the health or minimize damage or incapacity that could arise as a result of an accident or disease while attending school or any other of campus facilities or schools or in any other facility not belonging to the UPR, and to diagnose, treat, perform surgery or to administer therapeutic corrective measures deemed necessary, moreover to prescribe the medicines and treatments necessary in accordance to the laws of the Commonwealth of Puerto Rico. I also authorize the referral of my son/daughter to other doctors and/or hospitality institutions duly credited by the Department of Health of Puerto Rico. \_\_\_\_\_

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Student Number**

State of \_\_\_\_\_.

County of \_\_\_\_\_.

On \_\_\_\_\_ before me, \_\_\_\_\_

personally appeared \_\_\_\_\_, personally known to me by his/hers personal circumstances as expressed and of whom I attest to personally know.

**STAMP**  
**NOTARY PUBLIC'S SIGNATURE**