MEDICAL CONSENT FORM

In the event of an emergency where I, or any other person that I designate as the emergency contact person for (participant’s name): ______________________________, who I am responsible for, cannot be informed of the student’s health status and consulted for medical care instruction, I authorize Oregon Health & Science University to provide immediate medical care if the situation requires medical intervention.

Emergency Contact Information

First contact:
Name: _______________________________________ Relationship: ___________________
Home: _____________________ Work: _____________________ Cell:_________________

Second contact:
Name: _______________________________________ Relationship: ___________________
Home: _____________________ Work: _____________________ Cell:_________________

Is this student currently covered under a health insurance (check one)?  ____ Yes  ____ No
If yes, please provide name of health insurance: ______________________________________

Parent or Guardian: ___________________________ Date: ________________
(print full name)

Parent or Guardian signature: ________________________________

Please return to:
OHSU School of Dentistry
Office of Admissions and Student Affairs
MC: SD-SA
2730 SW Moody Ave.
Portland, OR 97201-5042