2015 Dive into Dentistry

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 #/pager:____________

Second contact:
Name: ___________________________________ Relationship: ___________________
Home #: ___________________ Work #: ___________________ Cell #/pager:____________

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
Mail code: SD-SA
2730 SW Moody Ave.
Portland, OR 97201-5042