2018 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