



**Oregon Health & Science University  
School of Dentistry  
2011-2012 Dental Explorer Program**

**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  
611 SW Campus Drive, Room 601  
Portland, OR 97239-3097