School of DENTISTRY

OHSU

OHSU School of Dentistry
2019-2020 Dental Explorer Program

MEDICAL CONSENT FORM

(Please complete consent form legibly in print.)

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