Oregon Health & Science University
School of Dentistry
2012-2013 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