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|  | **Oregon State Hospital** Minor Visitor Application |  |

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| **Instructions:** Fill out this application with your personal information. Information must be complete and legible.   * Type answers, then print out form; or * Hand write your answers in print (*no cursive*).   **Return application by any of the following methods:**  **1. Return to a staff member at the main lobby window of the campus you are visiting.**  **2. Return by mail to the appropriate address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | For Salem Patients:Oregon State Hospital, Salem RECEPTION  2600 Center Street NE  Salem, Oregon 97301 | | | | | | | | | | | | For Junction City Patients:Oregon State Hospital, Junction City RECEPTION 29398 Recovery Way Junction City, Oregon 97448 | | | | | | | | | | | | | | | | | | | |
| **3. By fax:** | | | | | | | | | | **4. By scanning and emailing to:** | | | | | | | | | | | | | | | | | | | | | | |
|  | | Salem: 503-945-2807  Junction City: 541-465-3007 | | | | | | | | |  | Salem: [SalemOSH.CommCenterLEDS@state.or.us](mailto:SalemOSH.CommCenterLEDS@state.or.us)  Junction City: [JC.BusinessServices@state.or.us](mailto:JC.BusinessServices@state.or.us) | | | | | | | | | | | | | | | | | | | | |
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| This form may contain your personal information. If you return the form by email there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure email, consider using regular mail or fax. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Patient name:** | | | | | | |  | | | | | | | | | | | | | | **Unit:** | |  | | | | | | | | |  |
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| **Minor visitor information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | |  | | | | | | | | | | | | | Date of birth: | |  | | | | | | Gender: | |  | | | | |
| Mailing address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| City: | | |  | | | | | | | | | | | | | | | | | | State: | | |  | | | ZIP: | | | |  | |
| Relationship of minor to patient: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent or guardian** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | |  | | | | | | | | | | Mailing address: | | | |  | | | | | | | | | | | | |
| City: | | |  | | | | | | | | | | | | | | | | | | State: | | |  | | | ZIP: | | | |  | |
| How do would you like to be notified? | | | | | | | | | | | | | | Phone | | | | | Email | | | Mail | | | | | | | | | | |
| Email: | | | |  | | | | | | | | | | | | | | | | | | | Phone: | |  | | | | | | | |
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| **Parent/legal guardian permission for minor’s visit**  (*Note: Every applicant, including minors, must complete and submit a separate application*)  Oregon State Hospital requires that all non-emancipated persons under the age of 18 must have the approval of their legal guardian or the custodial parent and must be accompanied during the visit by an adult who is also approved to visit the same patient.  I hereby give my permission for (MINOR) to visit with the patient named above, who is receiving treatment in a secure treatment environment at the Oregon State Hospital. I do so with the understanding that neither Oregon State Hospital, nor any of its representatives, shall be or become liable or responsible for any loss, injury or damage to persons or property resulting directly or indirectly from any act. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Printed name of parent/legal guardian | | | | | | | | | | | | | | | | | Signature of parent/legal guardian | | | | | | | | | | | | | Date | | |

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|  | **For official use only** | | | | | | | | | |
|  | Received by: |  | | | Date: | |  | |  | |
|  | LEDS operator: | |  | Date: | |  | | Result: |  |  |
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