

The Maryland School for the Blind

**EMERGENCY (911) TRANSPORTATION CONSENT
and STUDENT INSURANCE INFORMATION
Health Center - School Year 2011-2012**

STUDENT NAME: _____

PARENT/GUARDIAN: _____

The Maryland School for the Blind is hereby authorized to transport, or have my child transported, to the hospital in the event of an emergency.

The 911 dispatcher will determine which area hospital my child will be transported to under the existing circumstances

By signing below, **I GRANT PERMISSION** for the above-named service to be provided for my child.

Signature of Parent/Guardian

Date

STUDENT HEALTH INSURANCE INFORMATION 2011-2012

PLEASE COMPLETE and **PROVIDE A COPY OF INSURANCE CARDS**

Card holder's name: _____

Card holder's address: _____

Card holder's phone number: _____

Card holder's Employer: _____

Patient Relationship to card holder: _____

Insurance Carrier Name: _____

Insurance Carrier Address: _____

Policy Number: _____ Group Number: _____

Group Name: _____ Effective Date: _____

MEDICAL ASSISTANCE/MCO INFORMATION

MDMA Number: _____

Member/Policy Number: _____

This consent is good for the current school year and the parent is responsible for obtaining the information.