

**THE MARYLAND SCHOOL FOR THE BLIND
HEALTH CENTER**

**EMERGENCY (911) TRANSPORTATION CONSENT
and STUDENT INSURANCE INFORMATION**

STUDENT NAME: _____

PARENT/GUARDIAN: _____

By signing below, 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.

Signature of Parent/Guardian

Date

STUDENT HEALTH INSURANCE INFORMATION 2009-2010

If no changes in insurance information, please provide copy of insurance card only.

For new students or students with insurance changes, PLEASE COMPLETE and PROVIDE A COPY OF INSURANCE CARDS

Card holder's name: _____

Card holder's address: _____

Card holder's phone number: _____

Card holder 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: _____