

**Parent**

**EMERGENCY (911) TRANSPORTATION**

**and STUDENT INSURANCE INFORMATION**

**Health Center - School Year 2023-2024**

STUDENT NAME: ****

PARENT/GUARDIAN: ****

ADDRESS: ****

PHONE: ****

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.

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**PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD**

**OR**

**COMPLETELY FILL IN THE STUDENT’S HEALTH INFORMATION BELOW**

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: 

Signature Parent/Guardian Date

**Printed Name of Parent/Guardian**

PB/LB/cic:4/13/23