EMERGENCY (911) TRANSPORTATION and STUDENT INSURANCE INFORMATION

Health Center – School Year 2024-25

Student's Name: Click or tap here to enter text.

Parent/Guardian: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone: Click or tap here to enter text.

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.

# 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: Click or tap here to enter text.

Card Holder's Address: Click or tap here to enter text.

Card Holder's Phone Number: Click or tap here to enter text.

Card Holder's Employer: Click or tap here to enter text.

Patient Relationship to Card Holder: Click or tap here to enter text.

Insurance Carrier Name: Click or tap here to enter text.

Insurance Carrier Address: Click or tap here to enter text.

Policy Number: Click or tap here to enter text.

Group Number: Click or tap here to enter text.

Group Name: Click or tap here to enter text.

Effective Date: Click or tap to enter a date.

# MEDICAL ASSISTANCE/MCO INFORMATION

MDMA Number: Click or tap here to enter text.

Member/Policy Number: Click or tap here to enter text.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

Printed Name of Parent/Guardian: Click or tap here to enter text.

PB/LB/cic:4/4/24