S2

2019 – 2020

MARYLAND SCHOOL FOR THE DEAF

MEDICAL INSURANCE INFORMATION FORM

(Must be completed and signed by a parent/guardian)

Student's Name: ______________________________
(Last) (First) (Middle)

MEDICAL INSURANCE INFORMATION

HEALTH INSURANCE INFORMATION	Health Insurance Provider	Prescription Drug Plan	Other Insurance
Name of Company Address and Phone Number			
Policy Number			
Name of Policy Holder			

*******Attach Photo Copy of All Insurance Cards (front and back)*******

SCHOOL INSURANCE: Yes ❑ No ❑

Physician's Name: **Phone Number:**

Allergies:

Health Concerns: **Restrictions**:

Date of Last Tetanus Shot: **Date of Last Physical:**

(Note: Student must have a completed current physical exam form to participate in any sport)

Consent for Medical Care:

In case of injury or sudden illness, I hereby authorize medical care to be provided by MSD Healthcare personnel. Further, I grant permission for any hospital or treatment facility to render immediate aid or emergency surgical care as might be required at the time for my child's health and safety. I understand that in order for medications to be administered, they must in the original pharmacy bottle with label attached and dated within one year. I also understand that over-the-counter medications must be accompanied with a written order from a physician. I give my permission for MSD personnel to administer such medications. Attempts to notify parents/guardians regarding a medical emergency will always begin immediately.

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Parent/Guardian's Name (PRINT)

______________________________ ____________________

Parent/Guardian's Signature **Date**

CC: **Student Support Services**
Health Center

Revised: 06/13/2019